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103D CONGRESS
1ST SESSION

H. R. 834

To provide for comprehensive health care access expansion and cost control through reform and simplification of private health care insurance and other means.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 4, 1993

Mr. GLICKMAN (for himself and Mr. MCCURDY) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, the Judiciary, Education and Labor, and Rules

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A BILL

To provide for comprehensive health care access expansion and cost control through reform and simplification of private health care insurance and other means.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''BasiCare Health Access and Cost Control Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMMEDIATE REFORMS

Subtitle A—Small Employer Health Insurance Market Reform

Sec. 101. General requirements.
Sec. 102. General issuance requirements.
Sec. 103. Specific contractual requirements.
Sec. 104. State compliance agreements.
Sec. 105. Definitions and other rules.
Sec. 106. Amendment to the Internal Revenue Code of 1986.
Sec. 107. Effective date.

Subtitle B—Community Health Services Expansion

Sec. 111. Establishment of grant program.
Sec. 112. Program to provide for expansion of federally qualified health centers.

Subtitle C—Expansion of Tax Incentives for Self-Employed Individuals

Sec. 121. Permanent increase in deductible health insurance costs for self-employed individuals.

Subtitle D—Expanding the Supply of Health Professionals in Rural Areas

Sec. 131. Expansion of National Health Service Corps.
Sec. 132. Tax incentives for practice in rural areas.

Subtitle E—Malpractice Reform

PART I—DEFINITIONS

Sec. 141. Definitions.

PART II—TORT REFORM OF HEALTH CARE LIABILITY ACTIONS

Sec. 142. Application to civil actions.
Sec. 143. Damages.
Sec. 144. Joint and several liability.
Sec. 145. Statute of limitations.
Sec. 146. Preemption.
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PART III—ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

Sec. 148. Grants for alternative dispute resolution systems.
Sec. 149. Establishment of advisory panel.
Sec. 150. Authorization.

PART IV—DEMONSTRATION PROJECTS FOR NO-FAULT COMPENSATION PROGRAMS

Sec. 151. Demonstration projects for no-fault compensation programs.

Subtitle F—Joint Ventures

Sec. 161. Amendment of the National Cooperative Research Act of 1984.

TITLE II—LONG-TERM REFORMS

Subtitle A—Establishment of Commission and Advisory Board

Sec. 201. The Commission on National Health Care Access and Reform.

Sec. 202. National Advisory Board.
Sec. 203. Authorization of appropriations.

Subtitle B—Reform and Standardization of Private Insurance

Sec. 211. Defining goals and guidelines of Commission.
Sec. 212. Development and submission of legislative proposal.
Sec. 213. Continuing duties and responsibilities of the Commission.
Sec. 214. BasiCare benefits package.
Sec. 215. Insurance responsibilities under BasiCare.
Sec. 216. BasiCare base premium rate.
Sec. 217. Employer responsibilities under BasiCare.
Sec. 218. Individual responsibilities under BasiCare.
Sec. 219. Self-insured plan requirements.
Sec. 220. Provider responsibilities under BasiCare.
Sec. 221. Development of standards for managed care plans.
Sec. 222. Preemption of provisions relating to managed care.

Subtitle C—Low-Income Assistance

Sec. 231. Transfer from medicaid to BasiCare.
Sec. 232. Low-income assistance with costs of BasiCare insurance.

Subtitle D—Congressional Consideration of Commission Recommendation

Sec. 241. Rules governing congressional consideration.

Subtitle E—Enforcement Provisions

Sec. 251. Enforcement provisions for carriers, providers, and employers.
Sec. 252. Enforcement provision for individuals.

Subtitle F—Financial Provisions

Sec. 261. BasiCare Trust Fund.
Sec. 262. Tax treatment of costs of BasiCare insurance.

Subtitle G—Definitions

Sec. 271. Definitions.

TITLE I—IMMEDIATE REFORMS

Subtitle A—Small Employer Health Insurance Market Reform

SEC. 101. GENERAL REQUIREMENTS.

Any person issuing an accident and health insurance contract to any small employer shall meet the requirements of sections 102 and 103.

SEC. 102. GENERAL ISSUANCE REQUIREMENTS.

(a) GENERAL RULE.—The requirements of this section are met if any person issuing an accident and health insurance contract to any small employer meets—

(1) the mandatory policy requirements of subsection (b), and

(2) the guaranteed issue requirements of subsection (c).

(b) MANDATORY POLICY REQUIREMENTS.—

(1) IN GENERAL.—The requirements of this subsection are met if any person issuing an accident and health insurance contract to any small employer makes available to such small employer an accident and health insurance contract which provides benefits which are identical to the core benefits described in subsection (d).

(2) PRICING AND MARKETING REQUIREMENTS.—The requirements of paragraph (1) are not met unless—

(A) the price at which the accident and health insurance contract is made available is not greater than the price for such contract determined on the same basis as prices for other accident and health insurance contracts within the same class of business made available by the person to small employers, and

(B) the accident and health insurance contract is made available to small employers using substantially the same marketing methods and other sales practices which are used in selling such other contracts.

(c) GUARANTEED ISSUE.—

(1) IN GENERAL.—The requirements of this subsection are met—

(A) if the person offering accident and health insurance contracts to small employers issues such contracts to any small employer seeking to enter into such a contract, and

(B) if the person offers a managed care arrangement in a State, or a geographic area within a State, to employers that are not small employers, the person offers such managed care arrangement to small employers in the State or geographic area.

(2) FINANCIAL CAPACITY EXCEPTION.—Paragraph (1)(A) shall not require any person to issue an accident and health insurance contract to the extent that the issuance of such contract would result in such person violating any financial solvency standards established by the State in which such contract is to be issued.

(3) EXCEPTIONS FOR CERTAIN EMPLOYERS.—Paragraph (1)(A) shall not apply to a failure to issue an accident and health insurance contract to a small employer if—

(A) the small employer is unable to pay the premium for such contract, or

(B) in the case of a small employer with fewer than 15 employees, such employer fails to enroll at least 60 percent of the employer's eligible employees for coverage under such contract.

(4) SIZE LIMITS FOR MANAGED CARE ARRANGEMENTS.—Paragraph (1)(B) shall not apply to any person who ceases to enroll new small employer groups in a managed care arrangement if it ceases to enroll any new employer groups in such arrangement.

(d) BENEFITS.—

(1) CORE BENEFITS.—For purposes of this section, the term ''core benefits'' means benefits which are the same benefits provided as of the date of the enactment of this Act under title XVIII of the Social Security Act to individuals entitled to benefits under part A, and enrolled for benefits under part B of such title.

(2) DEDUCTIBLES AND COPAYMENTS.—An accident and health insurance contract shall not be treated as providing the core benefits described in paragraph (1) unless the following requirements are met:

(A) DEDUCTIBLE.—The accident and health insurance contract does not require a deductible amount for any contract year in excess of $500 per individual or $1,000 per family with respect to the core benefits.

(B) LIMIT ON OUT-OF-POCKET EXPENSES.—The accident and health insurance contract does not require out-of-pocket expenses for any contract year in excess of $2,000 per individual or $3,000 per family for the core benefits.

(C) CHILDREN.—

(i) NO DEDUCTIBLES OR COINSURANCE.—In the case of children, there shall be no coinsurance, deductibles, or copayments applicable to covered benefits described in clause (ii).

(ii) ADDITIONAL PREVENTIVE BENEFITS.—Subject to the periodicity schedule established under clause (iii), benefits shall

be available for children under the accident and health insurance contract for the following items and services:

(I) Newborn and well-baby care, including normal newborn care and pediatrician services for high-risk deliveries.

(II) Well-child care, including routine office visits, routine immunizations (including the vaccine itself), routine laboratory tests, and preventive dental care.

(iii) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American Academy of Pediatrics, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in clause (ii) should be provided to healthy children.

(iv) CHILD DEFINED.—For purposes of this subparagraph, the term ''child'' means an individual who has not attained age 23.

(D) PREGNANCY-RELATED SERVICES.—

(i) NO DEDUCTIBLES OR COINSURANCE.—In the case of a pregnant woman, there shall be no coinsurance, deductibles, or copayments applicable to covered benefits described in clause (ii).

(ii) ADDITIONAL BENEFITS.—Subject to the periodicity schedule established under clause (iii), benefits shall be available for pregnant women under the accident and health insurance contract for the following items and services:

(I) Prenatal care, including care for all complications of pregnancy.

(II) Inpatient labor and delivery services.

(III) Postnatal care.

(IV) Postnatal family planning services.

(iii) PERIODICITY SCHEDULE.—The Secretary, in consultation with the American College of Obstetrics and Gynecology, shall establish a schedule of periodicity which reflects the general, appropriate frequency with which services listed in clause

(ii) should be provided to pregnant women without complications of pregnancy.

(iv) PREGNANT WOMAN.—For purposes of this subparagraph, the term ''pregnant woman'' means a woman who has been certified by a physician (in a manner specified by the Secretary) as being pregnant and such woman shall be a pregnant woman for the purposes of this subparagraph until the last day of the month in which the 60-day period beginning on the date of termination of the pregnancy ends.

(3) PREEMPTION.—To the extent that the laws of any State or local government regulate or otherwise provide any requirement relating to the benefits to be provided under an accident and health insurance contract which are inconsistent with the provisions of this Act, they are preempted.

SEC. 103. SPECIFIC CONTRACTUAL REQUIREMENTS.

(a) GENERAL RULE.—The requirements of this section are met if any person issuing an accident and health insurance contract to any small employer meets—

(1) the coverage requirements of subsection (b), and

(2) the rating requirements of subsection (c).

(b) COVERAGE REQUIREMENTS.—

(1) IN GENERAL.—The requirements of this subsection are met with respect to any accident and health contract if, under the terms and operation of the contract, the following requirements are met:

(A) GUARANTEED ELIGIBILITY.—No eligible employee (and the spouse or any dependent child (as defined in section 102(d)(2)(C)(iv)) of the employee eligible for coverage) may be excluded from coverage under the contract.

(B) LIMITATIONS ON COVERAGE OF PREEXISTING CONDITIONS.—Any limitation under the contract on any preexisting condition—

(i) may not extend beyond the 6-month period beginning with the date an insured individual is first covered by the contract, and

(ii) may only apply to preexisting conditions which manifested themselves, or for which medical care or advice was sought or recommended, during the 3-month period preceding the date an insured individual is first covered by the contract.

(C) GUARANTEED RENEWABILITY.—

(i) IN GENERAL.—The contract must be renewed at the election of the small employer unless the contract is terminated for cause.

(ii) CAUSE.—For purposes of this subparagraph, the term ''cause''—

(I) includes nonpayment of premiums, fraud or misrepresentation, noncompliance with contract provisions (including participation requirements), or misuse of network provisions, but

(II) does not include any reason related to risk characteristics.

(2) WAITING PERIODS.—Paragraph (1)(A) shall not apply to any period an eligible employee is excluded from coverage under the contract solely by reason of a requirement applicable to all employees that a minimum period of service with the employer is required before the employee is eligible for such coverage.

(3) DETERMINATION OF PERIODS FOR RULES RELATING TO PREEXISTING CONDITIONS.—For purposes of paragraph (1)(B), the date on which an in-

sured individual is first covered by an accident and health insurance contract shall be the earlier of—

(A) the date on which coverage under such contract begins, or

(B) the first day of any continuous period—

(i) during which the insured individual was covered under 1 or more other health insurance arrangements, and

(ii) which does not end more than 120 days before the date employment for the employer begins.

(4) CESSATION OF SMALL EMPLOYER HEALTH INSURANCE BUSINESS.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, a person shall not be treated as failing to meet the requirements of paragraph (1)(C) if such person terminates the class of business which includes the accident and health insurance contract.

(B) NOTICE REQUIREMENT.—Subparagraph (A) shall apply only if the person gives notice of the decision to terminate at least 90 days before the expiration of the contract.

(C) 5-YEAR MORATORIUM.—If, within 5 years of the year in which a person terminates a class of business under subparagraph (A), such person establishes a new class of business which includes contracts within the class of business so terminated, the issuance of such contracts in that year shall be treated as a failure to meet the requirements of paragraph (1)(C).

(D) TRANSFERS.—If, upon a failure to renew a contract to which subparagraph (A) applies, a person transfers such contract to another class of business, such transfer must be made without regard to any risk characteristic.

(c) RATING REQUIREMENTS.—The requirements of this subsection are met with respect to any accident and health contract if the following requirements are met:

(1) LIMITATION ON VARIATION OF PREMIUMS BETWEEN CLASSES OF BUSINESS.—

(A) IN GENERAL.—The base premium rate for any class of business of a person issuing an accident and health insurance contract to a small employer may not exceed the base premium rate for any other class of business by more than 20 percent.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply to a class of business if the applicable regulatory authority determines that—

(i) the class is one for which the person does not reject, and never has rejected, small employers included within the definition of employers eligible for the class of business or otherwise eligible employees and dependents who enroll on a timely basis, based upon their claims experience, health status, industry, or occupation,

(ii) the person does not transfer, and never has transferred, an accident and health insurance contract involuntarily into or out of the class of business, and

(iii) accident and health insurance contracts offered under the class of business are currently available for purchase by small employers at the time an exception to subparagraph (A) is sought by the person.

(2) LIMIT ON VARIATION IN PREMIUM RATES WITHIN A CLASS OF BUSINESS.—For a class of business of a person issuing an accident and health insurance contract to a small employer, the highest

premium rates charged during a rating period to small employers with similar demographic characteristics (including age, sex, and geography and not relating to claims experience, health status, industry, occupation, or duration of coverage since issue) for the same or similar coverage, or the highest rates which could be charged to such employers under the rating system for that class of business, shall not exceed an amount that is 1.5 times the base premium rate for the class of business for a rating period (or portion thereof) that occurs in the first 3 years in which this subsection is in effect, and 1.35 times the base premium rate thereafter.

(3) CONSISTENT APPLICATION OF RATING FACTORS.—In establishing premium rates for any accident and health insurance contract offered to small employers—

(A) the person making adjustments with respect to age, sex, or geography must apply such adjustments consistently across small employers, and

(B) no person may use a geographic area that is smaller than a county or smaller than an area that includes all areas in which the

first three digits of the zip code are identical, whichever is smaller.

(4) LIMIT ON TRANSFER OF EMPLOYERS AMONG CLASSES OF BUSINESS.—

(A) IN GENERAL.—A person issuing an accident and health insurance contract to a small employer may not transfer a small employer from one class of business to another without the consent of the employer.

(B) OFFERS TO TRANSFER.—The person may not offer to transfer a small employer from one class of business to another unless—

(i) the offer is made without regard to age, sex, geography, claims experience, health status, industry, occupation or the date on which the policy was issued, and

(ii) the same offer is made to all other small employers in the same class of business.

(5) LIMITS ON VARIATION IN PREMIUM INCREASES.—The percentage increase in the premium rate charged to a small employer for a new rating period (determined on an annual basis) may not exceed the sum of the percentage change in the base premium rate plus 5 percentage points.

(6) FULL DISCLOSURE OF RATING PRACTICES.—

(A) IN GENERAL.—At the time a person offers an accident and health insurance contract to a small employer, the person shall fully disclose to the employer all of the following:

(i) Rating practices for small employer accident and health insurance contracts, including rating practices for different populations and benefit designs.

(ii) The extent to which premium rates for the small employer are based on risk characteristics and on factors other than risk characteristics.

(iii) The provisions concerning the person's right to change premium rates, the extent to which premiums can be modified, and the factors which affect changes in premium rates.

(iv) The class of business within which the contract falls, including a description of the grouping of contracts within a class of business.

(B) NOTICE ON EXPIRATION.—A person issuing accident and health insurance contracts

to small employers shall provide for notice, at least 60 days before the date of expiration of the accident and health insurance contract, of the terms for renewal of the contract. Such notice shall include an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the small employer's accident and health insurance contract.

(7) ACTUARIAL CERTIFICATION.—Each person issuing an accident and health contract to a small employer shall file annually with the applicable regulatory authority a written statement by a qualified health actuary (or other individual acceptable to such authority) that, based upon an examination by the individual which includes a review of the appropriate records and of the actuarial assumptions of the person and methods used by the person in establishing premium rates for small employer accident and health insurance contracts—

(A) the person is in compliance with the applicable provisions of this subsection, and

(B) the rating methods are actuarially sound.

(8) RECORDKEEPING.—Each person issuing an accident and health insurance contract to a small employer shall retain for examination at its principal place of business a complete and detailed description of its rating and renewal underwriting practices and the information on which such practices are based, including the statement described in paragraph (7).

SEC. 104. STATE COMPLIANCE AGREEMENTS.

(a) AGREEMENTS.—The Secretary may, in the discretion of the Secretary, enter into an agreement with any State—

(1) to apply the standards set by the laws of such State for accident and health insurance contracts issued by any person to any small employer in lieu of the requirements of section 102, or

(2) to provide for the State to make the initial determination as to whether a person is in compliance with the provisions of section 102.

(b) STANDARDS.—An agreement may be entered into under subsection (a)(1) only if—

(1) the chief executive officer of the State requests such agreement be entered into,

(2) the Secretary determines that the State standards to be applied under the agreement will apply to substantially all accident and health insur-

ance contracts issued to small employers in such State, and

(3) the Secretary determines that the application of the State standards will carry out the purposes of section 102.

(c) LIMITATION ON WAIVER.—Any agreement entered into under subsection (a)(1) shall not waive the mandatory policy requirements under section 102(b).

(d) TERMINATION.—The Secretary shall terminate any agreement if the Secretary determines that the application of State standards ceases to carry out the purposes of this section.

SEC. 105. DEFINITIONS AND OTHER RULES.

For purposes of this subtitle:

(1) ACCIDENT AND HEALTH INSURANCE CONTRACT.—

(A) IN GENERAL.—The term ''accident and health insurance contract'' means a contract under which a person authorized under applicable State insurance laws provides a health insurance plan or arrangement to a small employer. Such term does not include any self-insured plan of an employer.

(B) CERTAIN CONTRACTS NOT COVERED.—The term ''accident and health insurance contract'' does not include any contract—

(i) which provides for accident only, dental only, or disability only coverage,

(ii) which provides coverage as a supplement to liability insurance,

(iii) which provides insurance arising out of a workmen's compensation or similar law, or automobile medical-payment insurance, or

(iv) which provides insurance which is required by law to be contained under any self-insured plan of an employer.

(2) BASE PREMIUM RATE.—The term ''base premium rate'' means, for each class of business for each rating period, the lowest premium rate which could have been charged under a rating system for that class of business by the person issuing accident and health insurance contracts to small employers with similar demographic or other relevant characteristics (including age, sex, and geography and not relating to claims experience, health status, industry, occupation or duration of coverage since issue) for

accident and health insurance contracts with the same or similar coverage.

(3) CLASS OF BUSINESS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term ''class of business'' means, with respect to a person, all of the small employers with an accident and health insurance contract issued by the person.

(B) DISTINCT GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), a distinct group of small employers with accident and health insurance contracts issued by a person may be treated as a class of business by such person if all of the contracts in such group—

(I) are marketed and sold through individuals and organizations that do not participate in the marketing or sale of other distinct groups by the person,

(II) have been acquired from another person as a distinct group, or

(III) are provided through an association with membership of not less than 25 small employers that has

been formed for purposes other than obtaining health insurance.

(ii) EXCEPTION ALLOWED.—Except as provided in subparagraph (C), a person may not establish more than one distinct group of small employers for each category specified in clause (i).

(C) SPECIAL RULE.—A person may establish up to 2 groups under each category in subparagraph (A) or (B) to account for differences in characteristics (other than differences in contract benefits) of accident and health insurance contracts that are expected to produce substantial variation in health care costs.

(4) MANAGED HEALTH CARE ARRANGEMENT.—The term ''managed health care arrangement'' means an arrangement which integrates the financing and delivery of health care services to covered individuals by employing the following:

(A) Contracts with selected health care providers to furnish health care services to members.

(B) The adoption of explicit standards for the selection and recertification of providers.

(C) An explicit, formal program for ongoing quality assurance and utilization review.

(D) Significant financial incentives for members to use the providers and procedures associated with the arrangement.

(5) CHARACTERISTICS.—

(A) IN GENERAL.—The term ''characteristics'' means, with respect to any insurance rating system, the factors used in determining rates.

(B) RISK CHARACTERISTICS.—The term ''risk characteristics'' means factors related to the health risks of individuals, including health status, prior claims experience, the duration since the date of issue of a health insurance plan or arrangement, industry, and occupation.

(C) GEOGRAPHIC FACTORS.—In applying geographic location as a characteristic, a person may not use for purposes of this subtitle areas smaller than Census Bureau designations of metropolitan statistical areas and nonmetropolitan statistical areas.

(6) ELIGIBLE EMPLOYEE.—The term ''eligible employee'' means, with respect to an employer, any employee who normally works at least 30 hours per

week for that employer. For purposes of this paragraph, the term ''employee'' includes a self-employed individual as defined in section 401(c)(1) of the Internal Revenue Code of 1986.

(7) PERSON.—The term ''person'' includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or in States which have distinct insurance licensure requirements, a multiple employer welfare arrangement.

(8) QUALIFIED HEALTH ACTUARY.—The term ''qualified health actuary'' means a member of the American Academy of Actuaries who is qualified by reason of prior and continuing education and relevant experience to render the actuarial opinion.

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, or the delegate of the Secretary.

(10) SMALL EMPLOYER.—The term ''small employer'' means, with respect to a calendar year, an employer who normally employs more than 1 but less than 51 eligible employees on a typical business day. For purposes of the preceding sentence, all employers covered under the same health insurance

plan or arrangement covered by a contract shall be treated as 1 employer.

SEC. 106. AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by adding at the end thereof the following new section:

"SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS FOR HEALTH INSURANCE.

''(a) GENERAL RULE.—In the case of any person issuing an accident and health insurance contract to a small employer, there is hereby imposed a tax on the failure of such person to meet at any time during any taxable year the applicable requirements of section 101 of the BasiCare Health Access and Cost Control Act. The Secretary of Health and Human Services shall determine whether any person meets the requirements of such section.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 35 percent of the gross premiums received during such taxable year with respect to all accident and health insur-

ance contracts issued to a small employer by the person on whom such tax is imposed.

''(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any accident and health insurance contract.

''(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or business (whether or not incor-

porated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

''(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the first date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(d) DEFINITIONS.—For purposes of this section the terms 'accident and health insurance contract', 'small employer', 'eligible employee', and 'person' shall have the same meanings given such terms under section 105 of the BasiCare Health Access and Cost Control Act.''.

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of such Code (relating to nondeductibility of certain taxes) is amended by inserting ''47,'' after ''46,''.

(c) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 is amended by adding at the end thereof the following new item:

''Sec. 5000A. Failure to satisfy certain standards for health insurance.''.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a) and (c) shall take effect on the date of the enactment of this Act.

(2) NONDEDUCTIBILITY OF TAX.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 1993.

SEC. 107. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 106 and subsection (b), this subtitle shall apply to contracts issued, or renewed, after the date of the enactment of this Act and before the effective date of the legislation described in section 212(a) or 213(a) of this Act.

(b) GUARANTEED ISSUE.—The provisions of section 102(c) shall apply to contracts which are issued, or renewed, after the date which is 12 months after the date of the enactment of this Act and before the effective date of the legislation described in section 212(a) or 213(a) of this Act.

Subtitle B—Community Health Services Expansion

SEC. 111. ESTABLISHMENT OF GRANT PROGRAM.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end thereof the following new section:

"SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.

''(a) ESTABLISHMENT.—The Secretary shall establish and administer a program to provide allotments to

States to enable such States to provide grants for the creation or enhancement of community-based primary health care entities that provide services to low-income or medically underserved populations.

''(b) ALLOTMENTS TO STATES.—

''(1) IN GENERAL.—From the amount available for allotment under subsection (h) for a fiscal year, the Secretary shall allot to each State an amount equal to the product of the grant share of the State (as determined under paragraph (2)) multiplied by such amount available.

''(2) GRANT SHARE.—

''(A) IN GENERAL.—For purposes of paragraph (1), the grant share of a State shall be the product of the need-adjusted population of the State (as determined under subparagraph (B)) multiplied by the Federal matching percentage of the State (as determined under subparagraph (C)), expressed as a percentage of the sum of the products of such factors for all States.

''(B) NEED-ADJUSTED POPULATION.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the need-adjusted population of a State shall be the product of

the total population of the State (as estimated by the Secretary of Commerce) multiplied by the need index of the State (as determined under clause (ii)).

''(ii) NEED INDEX.—For purposes of clause (i), the need index of a State shall be the ratio of—

''(I) the weighted sum of the geographic percentage of the State (as determined under clause (iii)), the poverty percentage of the State (as determined under clause (iv)), and the multiple grant percentage of the State (as determined under clause (v)); to

''(II) the general population percentage of the State (as determined under clause (vi)).

''(iii) GEOGRAPHIC PERCENTAGE.—

''(I) IN GENERAL.—For purposes of clause (ii)(I), the geographic percentage of the State shall be the estimated population of the State that is residing in nonurbanized areas (as determined under subclause (II)) ex-

pressed as a percentage of the total nonurbanized population of all States.

''(II) NONURBANIZED POPULATION.—For purposes of subclause (I), the estimated population of the State that is residing in nonurbanized areas shall be one minus the urbanized population of the State (as determined using the most recent decennial census), expressed as a percentage of the total population of the State (as determined using the most recent decennial census), multiplied by the current estimated population of the State.

''(iv) POVERTY PERCENTAGE.—For purposes of clause (ii)(I), the poverty percentage of the State shall be the estimated number of people residing in the State with incomes below 200 percent of the income official poverty line (as determined by the Office of Management and Budget) expressed as a percentage of the total number of such people residing in all States.

''(v) MULTIPLE GRANT PERCENTAGE.—For purposes of clause (ii)(I), the multiple grant percentage of the State shall be the amount of Federal funding received by the State under grants awarded under sections 329, 330, and 340, expressed as a percentage of the total amounts received under such grants by all States. With respect to a State, such percentage shall not exceed twice the general population percentage of the State under clause (vi) or be less than one-half of the States general population percentage.

''(vi) GENERAL POPULATION PERCENTAGE.—For purposes of clause (ii)(II), the general population percentage of the State shall be the total population of the State (as determined by the Secretary of Commerce) expressed as a percentage of the total population of all States.

''(C) FEDERAL MATCHING PERCENTAGE.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the Federal matching percentage of the State shall be equal to

one, less the State matching percentage (as determined under clause (ii)).

''(ii) STATE MATCHING PERCENTAGE.—For purposes of clause (i), the State matching percentage of the State shall be 0.25 multiplied by the ratio of the total taxable resource percentage (as determined under clause (iii)) to the need-adjusted population of the State (as determined under subparagraph (B)).

''(iii) TOTAL TAXABLE RESOURCE PERCENTAGE.—For purposes of clause (ii), the total taxable resources percentage of the State shall be the total taxable resources of a State (as determined by the Secretary of the Treasury) expressed as a percentage of the sum of the total taxable resources of all States.

''(3) ANNUAL ESTIMATES.—

''(A) IN GENERAL.—If the Secretary of Commerce does not produce the annual estimates required under paragraph (2)(B)(iv), such estimates shall be determined by multiplying the percentage of the population of the State that is below 200 percent of the income

official poverty line as determined using the most recent decennial census by the most recent estimate of the total population of the State. Except as provided in subparagraph (B), the calculations required under this subparagraph shall be made based on the most recent 3-year average of the total taxable resources of individuals within the State.

''(B) DISTRICT OF COLUMBIA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the District of Columbia shall be based on the most recent 3-year average of the personal income of individuals residing within the District as a percentage of the personal income for all individuals residing within the District, as determined by the Secretary of Commerce.

''(4) MATCHING REQUIREMENT.—A State that receives an allotment under this section shall make available State resources (either directly or indirectly) to carry out this section in an amount that shall equal the State matching percentage for the State (as determined under paragraph (2)(C)(ii)) divided by the Federal matching percentage (as determined under paragraph (2)(C)).

''(c) APPLICATION.—

''(1) IN GENERAL.—To be eligible to receive an allotment under this section, a State shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may by regulation require.

''(2) ASSURANCES.—A State application submitted under paragraph (1) shall contain an assurance that—

''(A) the State will use amounts received under its allotment consistent with the requirements of this section; and

''(B) the State will provide, from non-Federal sources, the amounts required under subsection (b)(4).

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—The State shall use amounts received under this section to award grants to eligible public and nonprofit private entities, or consortia of such entities, within the State to enable such entities or consortia to provide services of the type described in paragraph (2) of section 329(h) to low-income or medically underserved populations.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity or consortium shall—

''(A) prepare and submit to the administering entity of the State, an application at such time, in such manner, and containing such information as such administering entity may require, including a plan for the provision of services of the type described in paragraph (3);

''(B) provide assurances that services will be provided under the grant at fee rates established or determined in accordance with section 330(e)(3)(F); and

''(C) provide assurances that in the case of services provided to individuals with health insurance, such insurance shall be used as the primary source of payment for such services.

''(3) SERVICES.—The services to be provided under a grant awarded under paragraph (1) shall include—

''(A) one or more of the types of primary health services described in section 330(b)(1);

''(B) one or more of the types of supplemental health services described in section 330(b)(2); and

''(C) any other services determined appropriate by the administering entity of the State.

''(4) TARGET POPULATIONS.—Entities or consortia receiving grants under paragraph (1) shall, in providing the services described in paragraph (3), substantially target populations of low-income or medically underserved populations within the State who reside in medically underserved or health professional shortage areas, areas certified as underserved under the rural health clinic program, or other areas determined appropriate by the administering entity of the State, within the State.

''(5) PRIORITY.—In awarding grants under paragraph (1), the State shall—

''(A) give priority to entities or consortia that can demonstrate through the plan submitted under paragraph (2) that—

''(i) the services provided under the grant will expand the availability of primary care services to the maximum number of low-income or medically underserved populations who have no access to such care on the date of the grant award; and

''(ii) the delivery of services under the grant will be cost-effective; and

''(B) ensure that an equitable distribution of funds is achieved among urban and rural entities or consortia.

''(e) REPORTS AND AUDITS.—Each State shall prepare and submit to the Secretary annual reports concerning the State's activities under this section which shall be in such form and contain such information as the Secretary determines appropriate. Each such State shall establish fiscal control and fund accounting procedures as may be necessary to assure that amounts received under this section are being disbursed properly and are accounted for, and include the results of audits conducted under such procedures in the reports submitted under this subsection.

''(f) PAYMENTS.—

''(1) ENTITLEMENT.—Each State for which an application has been approved by the Secretary under this section shall be entitled to payments under this section for each fiscal year in an amount not to exceed the State's allotment under subsection (b) to be expended by the State in accordance with the terms of the application for the fiscal year for which the allotment is to be made.

''(2) METHOD OF PAYMENTS.—The Secretary may make payments to a State in installments, and

in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

''(3) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under subsection (b) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

''(g) DEFINITION.—As used in this section, the term 'administering entity of the State' means the agency or official designated by the chief executive officer of the State to administer the amounts provided to the State under this section.

''(h) FUNDING.—Notwithstanding any other provision of law, the Secretary shall use 50 percent of the amounts that the Secretary is required to utilize under section 330B(h) in each fiscal year to carry out this section.''.

SEC. 112. PROGRAM TO PROVIDE FOR EXPANSION OF FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) (as amended by section 111) is further amended by adding at the end thereof the following new section:

''SEC. 330B. PROGRAM TO PROVIDE FOR EXPANSION OF FEDERALLY QUALIFIED HEALTH CENTERS.

''(a) ESTABLISHMENT OF HEALTH SERVICES ACCESS PROGRAM.—From amounts appropriated under this section, the Secretary shall, acting through the Bureau of Health Care Delivery Assistance, award grants under this section to federally qualified health centers (hereafter referred to in this section as 'FQHCs') and other entities and organizations submitting applications under this section (as described in subsection (c)) for the purpose of providing access to services for medically underserved populations (as defined in section 330(b)(3)) or in high impact areas (as defined in section 329(a)(5)) not currently being served by a FQHC.

''(b) ELIGIBILITY FOR GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants under this section to entities or organizations described in this paragraph and paragraph (2) which have submitted a proposal to the Secretary to expand such entities or organizations operations (including expansions to new sites (as determined necessary by the Secretary)) to serve medically underserved populations or high impact areas not currently served by a FQHC and which—

''(A) have as of the date of enactment of the BasiCare Health Access and Cost Control

Act, been certified by the Secretary as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

''(B) have submitted applications to the Secretary to qualify as FQHCs under section 1905(l)(2)(B) of the Social Security Act; or

''(C) have submitted a plan to the Secretary which provides that the entity or organization will meet the requirements to qualify as a FQHC when operational.

''(2) NON-FQHC ENTITIES.—

''(A) ELIGIBILITY.—The Secretary shall also make grants under this section to any public or private nonprofit agency, or any health care entity or organization which—

''(i) meets the requirements necessary to qualify as a FQHC, except the requirement that such agency, entity, or organization has a consumer majority governing board,

''(ii) has submitted a proposal to the Secretary to provide those services provided by a FQHC as defined in section 1905(l)(2)(B) of the Social Security Act, and

''(iii) is designed to promote access to primary care services or to reduce reliance on hospital emergency rooms or other high cost providers of primary health care services,

provided that the proposal described in clause (ii) is developed by the agency, entity, or organization (or such agencies, entities, or organizations acting in a consortium in a community) with the review and approval of the Governor of the State in which such agency, entity, or organization is located.

''(B) LIMITATION.—The Secretary shall provide in making grants to entities or organizations described in this paragraph that not more than 10 percent of the funds provided for grants under this section shall be made available for grants to such entities or organizations.

''(c) APPLICATION REQUIREMENTS.—

''(1) IN GENERAL.—In order to be eligible to receive a grant under this section, a FQHC or other entity or organization must submit an application in such form and at such time as the Secretary shall prescribe and which meets the requirements of this subsection.

''(2) REQUIREMENTS.—An application submitted under this section must provide—

''(A)(i) for a schedule of fees or payments for the provision of the services provided by the entity or organization designed to cover its reasonable costs of operations; and

''(ii) for a corresponding schedule of discounts to be applied to such fees or payments, based upon the patient's ability to pay (determined by using a sliding scale formula based on the income of the patient);

''(B) assurances that the entity or organization provides services to persons who are eligible for benefits under title XVIII of the Social Security Act, for medical assistance under title XIX of such Act, or for assistance for medical expenses under any other public assistance program or private health insurance program; and

''(C) assurances that the entity or organization has made and will continue to make every reasonable effort to collect reimbursement for services—

''(i) from persons eligible for assistance under any of the programs described in subparagraph (B); and

''(ii) from patients not entitled to benefits under any such programs.

''(d) LIMITATIONS ON USE OF FUNDS.—

''(1) IN GENERAL.—From the amounts awarded to a FQHC or other entity or organization under this section, funds may be used for purposes of planning but may only be expended for the costs of—

''(A) assessing the needs of the populations or proposed areas to be served;

''(B) preparing a description of how the needs identified will be met; and

''(C) development of an implementation plan that addresses—

''(i) recruitment and training of personnel; and

''(ii) activities necessary to achieve operational status in order to meet FQHC requirements under 1905(l)(2)(B) of the Social Security Act.

''(2) RECRUITING, TRAINING, AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this section, funds may be used for the purposes of paying for the costs of recruiting, training, and compensating staff (clinical and associated administrative personnel (to the ex-

tent such costs are not already reimbursed under title XIX of the Social Security Act or any other State or Federal program)) to the extent necessary to allow the entity or organization to operate at new or expanded existing sites.

''(3) FACILITIES AND EQUIPMENT.—From the amounts awarded to an entity or organization under this section, funds may be expended for the purposes of acquiring facilities and equipment but only for the costs of—

''(A) construction of new buildings (to the extent that new construction is found to be the most cost-efficient approach by the Secretary);

''(B) acquiring, expanding, or modernizing existing facilities;

''(C) purchasing essential (as determined by the Secretary) equipment; and

''(D) amortization of principal and payment of interest on loans obtained for purposes of site construction, acquisition, modernization, or expansion, as well as necessary equipment.

''(4) SERVICES.—From the amounts awarded to an entity or organization under this section, funds may be expended for the payment of services but only for the costs of—

''(A) providing or arranging for the provision of all services through the entity or organization necessary to qualify such entity or organization as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

''(B) providing or arranging for any other service that a FQHC may provide and be reimbursed for under title XIX of the Social Security Act; and

''(C) providing any unreimbursed costs of providing services as described in section 330(a) to patients.

''(e) PRIORITIES IN THE AWARDING OF GRANTS.—

''(1) CERTIFIED FQHCS.—The Secretary shall give priority in awarding grants under this section to entities and organizations which have, as of the date of enactment of the BasiCare Health Access and Cost Control Act, been certified as a FQHC under section 1905(l)(2)(B) of the Social Security Act and which have submitted a proposal to the Secretary to expand their operations (including expansion to new sites) to serve medically underserved populations for high impact areas not currently served by a FQHC. The Secretary shall give first priority in awarding grants under this section to

those FQHCs or other entities or organizations which propose to serve populations with the highest degree of unmet need, and which can demonstrate the ability to expand their operations in the most efficient manner.

''(2) QUALIFIED FQHCS.—The Secretary shall give second priority in awarding grants to entities and organizations which have submitted applications to the Secretary which demonstrate that the entities or organizations will qualify as FQHCs under section 1905(l)(2)(B) of the Social Security Act before they provide or arrange for the provision of services supported by funds awarded under this section, and which are serving or proposing to serve medically underserved populations or high impact areas which are not currently served (or proposed to be served) by a FQHC.

''(3) EXPANDED SERVICES AND PROJECTS.—The Secretary shall give third priority in awarding grants in subsequent years to those FQHCs or other entities or organizations which have provided for expanded services and projects and are able to demonstrate that such entities or organizations will incur significant unreimbursed costs in providing such expanded services.

''(f) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent that a FQHC or other entity or organization receiving funds under this section is reimbursed from another source for the provision of services to an individual, and does not use such increased reimbursement to expand services furnished, to expand areas served, to compensate for costs of unreimbursed services provided to patients, or to promote recruitment, training, or retention of personnel, such excess revenues shall be returned to the Secretary.

''(g) TERMINATION OF GRANTS.—

''(1) FAILURE TO MEET FQHC REQUIREMENTS.—

''(A) IN GENERAL.—With respect to any entity or organization that is receiving funds awarded under this section and which subsequently fails to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act or is an entity or organization that is not required to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act but fails to meet the requirements of this section, the Secretary shall terminate the award of

funds under this section to such entity or organization.

''(B) NOTICE.—Prior to any termination of funds under this section to an entity or organization, the entity or organization shall be entitled to 60 days' prior notice of termination and, as provided by the Secretary in regulations, an opportunity to correct any deficiencies in order to allow the entity or organization to continue to receive funds under this section.

''(2) REQUIREMENTS.—Upon any termination of funding under this section, the Secretary may (to the extent practicable)—

''(A) sell any property (including equipment) acquired or constructed by the entity or organization using funds made available under this section or transfer such property to another FQHC, except that the Secretary shall reimburse any costs which were incurred by the entity or organization in acquiring or constructing such property (including equipment) which were not supported by grants under this section; and

''(B) recoup any funds provided to an entity or organization terminated under this section.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $600,000,000 for each of the fiscal years 1994 through 1998.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective with respect to services furnished by a federally qualified health center or other qualifying entity or organization described in this section beginning on or after the date of enactment of this Act.

Subtitle C—Expansion of Tax Incentives for Self-Employed Individuals

SEC. 121. PERMANENT INCREASE IN DEDUCTIBLE HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended by striking ''25 percent'' and inserting ''100 percent''.

(b) PERMANENT DEDUCTION.—Section 162(l) of such Code is amended by striking paragraph (6).

(c) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after the date of enactment of this Act.

Subtitle D—Expanding the Supply of Health Professionals in Rural Areas

SEC. 131. EXPANSION OF NATIONAL HEALTH SERVICE CORPS.

Section 338H(b) of the Public Health Service Act (42 U.S.C. 254q(b)) is amended—

(1) in paragraph (1), by striking ''and such sums'' and all that follows through the end thereof and inserting ''$120,000,000 for each of the fiscal years 1992 through 1997.''; and

(2) in paragraph (2)—

(A) by redesignating subparagraphs (A) and (B) as subparagraphs (B) and (C), respectively; and

(B) by inserting before subparagraph (B) (as so redesignated) the following new subparagraph:

''(A) IN GENERAL.—Of the amount appropriated under paragraph (1) for each fiscal

year, the Secretary shall utilize 25 percent of such amount to carry out section 338A and 75 percent of such amount to carry out section 338B.''.

SEC. 132. TAX INCENTIVES FOR PRACTICE IN RURAL AREAS.

(a) NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.—

(1) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is amended by inserting after section 25 the following new section:

''SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.

''(a) ALLOWANCE OF CREDIT.—In the case of a qualified primary health services provider, there is allowed as a credit against the tax imposed by this chapter for any taxable year in a mandatory service period an amount equal to the product of—

''(1) the lesser of—

''(A) the number of months of such period occurring in such taxable year, or

''(B) 36 months, reduced by the number of months taken into account under this paragraph with respect to such provider for all pre-

ceding taxable years (whether or not in the same mandatory service period), multiplied by

''(2) $1,000 ($500 in the case of a qualified primary health services provider who is a physician assistant or a nurse practitioner).

''(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means any physician, physician assistant, or nurse practitioner who for any month during a mandatory service period is certified by the Bureau to be a primary health services provider who—

''(1) is providing primary health services—

''(A) full time, and

''(B) to individuals at least 80 percent of whom reside in a rural health professional shortage area,

''(2) is not receiving during such year a scholarship under the National Health Service Corps Scholarship Program or a loan repayment under the National Health Service Corps Loan Repayment Program,

''(3) is not fulfilling service obligations under such Programs, and

''(4) has not defaulted on such obligations.

''(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) BUREAU.—The term 'Bureau' means the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration of the United States Public Health Service.

''(2) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

''(3) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(3) of the Social Security Act.

''(4) PRIMARY HEALTH SERVICES PROVIDER.—The term 'primary health services provider' means a provider of primary health services (as defined in section 330(b)(1) of the Public Health Service Act).

''(5) RURAL HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'rural health professional shortage area' means—

''(A) a class 1 or class 2 rural health professional shortage area (as defined in section 332(a)(1)(A) of the Public Health Service Act) in a rural area (as determined under section 1886(d)(2)(D) of the Social Security Act), or

''(B) an area which is determined by the Secretary of Health and Human Services as equivalent to an area described in subparagraph (A) and which is designated by the Bureau of the Census as not urbanized.

''(C) a community that is certified as underserved by the Secretary for purposes of participation in the rural health clinic program under title XVIII of the Social Security Act.

''(e) RECAPTURE OF CREDIT.—

''(1) IN GENERAL.—If, during any taxable year, there is a recapture event, then the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

''(A) the applicable percentage, and

''(B) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

''(2) APPLICABLE RECAPTURE PERCENTAGE.—

''(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	The applicable recapture percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Months 61 and thereafter	0.

''(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

''(3) RECAPTURE EVENT DEFINED.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means the failure of the taxpayer to be a qualified primary health services provider for any month during any mandatory service period.

''(B) CESSATION OF DESIGNATION.—The cessation of the designation of any area as a rural health professional shortage area after the beginning of the mandatory service period for any taxpayer shall not constitute a recapture event.

''(C) SECRETARIAL WAIVER.—The Secretary may waive any recapture event caused by extraordinary circumstances.

''(4) NO CREDITS AGAINST TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part.''.

(2) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 25 the following new item:

''Sec. 25A. Primary health services providers.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after the date of the enactment of this Act.

(b) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 136 as section 137 and by inserting after section 135 the following new section:

''SEC. 136. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(2) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(3) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 136 and inserting the following:

''Sec. 136. National Health Service Corps loan repayments.
''Sec. 137. Cross references to other Acts.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

(c) EXPENSING OF MEDICAL EQUIPMENT.—

(1) IN GENERAL.—Section 179 of the Internal Revenue Code of 1986 (relating to election to expense certain depreciable business assets) is amended—

(A) by striking paragraph (1) of subsection (b) and inserting the following:

''(1) DOLLAR LIMITATION.—

''(A) GENERAL RULE.—The aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $10,000.

''(B) RURAL HEALTH CARE PROPERTY.—In the case of rural health care property, the aggregate cost which may be taken into account under subsection (a) for any taxable year shall not exceed $25,000, reduced by the amount otherwise taken into account under subsection (a) for such year.''; and

(B) by adding at the end of subsection (d) the following new paragraph:

''(11) RURAL HEALTH CARE PROPERTY.—For purposes of this section, the term 'rural health care property' means section 179 property used by a physician (as defined in section 1861(r) of the Social Security Act) in the active conduct of such physician's full-time trade or business of providing primary health services (as defined in section 330(b)(1) of the Public Health Service Act) in a rural health

professional shortage area (as defined in section 25A(d)(5)).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to property placed in service in taxable years beginning after the date of enactment of this Act.

(d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY MEDICAL PROFESSIONALS PRACTICING IN RURAL AREAS.—

(1) INTEREST ON STUDENT LOANS NOT TREATED AS PERSONAL INTEREST.—Section 163(h)(2) of the Internal Revenue Code of 1986 (defining personal interest) is amended by striking ''and'' at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting '', and'', and by adding at the end thereof the following new subparagraph:

''(F) any qualified medical education interest (within the meaning of subsection (k)).''.

(2) QUALIFIED MEDICAL EDUCATION INTEREST DEFINED.—Section 163 of such Code (relating to interest expenses) is amended by redesignating subsection (k) as subsection (l) and by inserting after subsection (j) the following new subsection:

''(k) QUALIFIED MEDICAL EDUCATION INTEREST OF MEDICAL PROFESSIONALS PRACTICING IN RURAL AREAS.—

''(1) IN GENERAL.—For purposes of subsection (h)(2)(F), the term 'qualified medical education interest' means an amount which bears the same ratio to the interest paid on qualified educational loans during the taxable year by an individual performing services under a qualified rural medical practice agreement as—

''(A) the number of months during the taxable year during which such services were performed, bears to

''(B) the number of months in the taxable year.

''(2) DOLLAR LIMITATION.—The aggregate amount which may be treated as qualified medical education interest for any taxable year with respect to any individual shall not exceed $5,000.

''(3) QUALIFIED RURAL MEDICAL PRACTICE AGREEMENT.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified rural medical practice agreement' means a written agreement between an individual and an ap-

plicable rural community under which the individual agrees—

''(i) in the case of a medical doctor, upon completion of the individual's residency (or internship if no residency is required), or

''(ii) in the case of a registered nurse, nurse practitioner, or physician's assistant, upon completion of the education to which the qualified education loan relates,

to perform full-time services as such a medical professional in the applicable rural community for a period of 24 consecutive months. An individual and an applicable rural community may elect to have the agreement apply for 36 consecutive months rather than 24 months.

''(B) SPECIAL RULE FOR COMPUTING PERIODS.—An individual shall be treated as meeting the 24 or 36 consecutive month requirement under subparagraph (A) if, during each 12-consecutive month period within either such period, the individual performs full-time services as a medical doctor, registered nurse, nurse practitioner, or physician's assistant, whichever applies, in the applicable rural community during

9 of the months in such 12-consecutive month period. For purposes of this subsection, an individual meeting the requirements of the preceding sentence shall be treated as performing services during the entire 12-month period.

''(C) APPLICABLE RURAL COMMUNITY.—The term 'applicable rural community' means—

''(i) any political subdivision of a State which—

''(I) has a population of 5,000 or less, and

''(II) has a per capita income of $15,000 or less, or

''(ii) an Indian reservation which has a per capita income of $15,000 or less.

''(4) QUALIFIED EDUCATIONAL LOAN.—The term 'qualified educational loan' means any indebtedness to pay qualified tuition and related expenses (within the meaning of section 117(b)) and reasonable living expenses—

''(A) which are paid or incurred—

''(i) as a candidate for a degree as a medical doctor at an educational institution described in section 170(b)(1)(A)(ii), or

''(ii) in connection with courses of instruction at such an institution necessary for certification as a registered nurse, nurse practitioner, or physician's assistant, and

''(B) which are paid or incurred within a reasonable time before or after such indebtedness is incurred.

''(5) RECAPTURE.—If an individual fails to carry out a qualified rural medical practice agreement during any taxable year, then—

''(A) no deduction with respect to such agreement shall be allowable by reason of subsection (h)(2)(F) for such taxable year and any subsequent taxable year, and

''(B) there shall be included in gross income for such taxable year the aggregate amount of the deductions allowable under this section (by reason of subsection (h)(2)(F)) for all preceding taxable years.

''(6) DEFINITIONS.—For purposes of this subsection, the terms 'registered nurse', 'nurse practitioner', and 'physician's assistant' have the meaning given such terms by section 1861 of the Social Security Act.''.

(3) DEDUCTION ALLOWED IN COMPUTING ADJUSTED GROSS INCOME.—Section 62(a) of such Code is amended by inserting after paragraph (13) the following new paragraph:

''(14) INTEREST ON STUDENT LOANS OF RURAL HEALTH PROFESSIONALS.—The deduction allowable by reason of section 163(h)(2)(F) (relating to student loan payments of medical professionals practicing in rural areas).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to taxable years beginning after the date of the enactment of this Act.

Subtitle E—Malpractice Reform

PART I—DEFINITIONS

SEC. 141. DEFINITIONS.

For purposes of this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term ''alternative dispute resolution system'' means a system that is enacted or adopted by a State to resolve health care liability actions as an alternative to a judicial proceeding in a Federal or State court.

(2) CONCERTED ACTION AND ACTING IN CONCERT.—The terms ''concerted action'' and ''acting in concert'' mean the participation in joint conduct

by two or more persons who agree to jointly participate in such conduct with actual knowledge of the wrongfulness of the conduct.

(3) ECONOMIC LOSSES.—The term ''economic losses'' means losses for health care provider and medical expenses, lost wages, lost employment, and other pecuniary losses.

(4) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means any civil action or proceeding in any judicial tribunal brought pursuant to Federal or State law against a health care provider alleging that injury was suffered by the claimant as a result of any act or omission by such provider, without regard to the theory of liability asserted in the action. Such term includes a claim, third-party claim, cross-claim, counter-claim, or contribution-claim.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means—

(A) any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State; and

(B) any organization or institution that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) INJURY.—The term ''injury'' means any injury, illness, disease, or other harm suffered by an individual as a result of the provision of health care services by a health care provider.

(7) NONECONOMIC LOSSES.—The term ''noneconomic losses'' means losses for physical and emotional pain, suffering, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of companionship, consortium, and other nonpecuniary losses.

(8) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(9) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

PART II—TORT REFORM OF HEALTH CARE LIABILITY ACTIONS

SEC. 142. APPLICATION TO CIVIL ACTIONS.

This part shall apply to any health care liability action brought in any Federal or State court. This part shall not be construed to create or effect any cause of action or theory of liability recognized in any Federal or State proceeding.

SEC. 143. DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of damages which may be awarded to an individual and the family members of such individual for noneconomic losses resulting from an injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of health care providers against whom such action is brought or the number of such actions brought with respect to the injury.

(b) PAYMENTS.—With respect to a health care liability action, no person may be required to pay more than $100,000 in a single payment for an award of damages for economic or noneconomic losses, but such person shall be permitted to make such payments on a periodic basis. The periods for such payments shall be determined by the court.

(c) MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.—

(1) IN GENERAL.—The total amount of damages received by an individual in connection with a health care liability action shall be reduced, in accordance with paragraph (2), by any other payment which has been made or which will be made to such individual to compensate such individual for an injury, including payments under—

(A) Federal or State disability or sickness programs;

(B) Federal, State, or private health insurance programs;

(C) private disability insurance programs;

(D) employer wage continuation programs; and

(E) any other source of payment intended to compensate such individual for such injury.

(2) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an injury shall be reduced under paragraph (1) shall be—

(A) the total amount of any payments (other than such award) which have been made or which will be made to such individual to compensate such individual for such injury; minus

(B) the amount paid by such individual (or by the spouse, parent, or legal guardian of such individual) to secure the payments described in subparagraph (A).

(d) PUNITIVE DAMAGES.—

(1) LIMITATION.—With respect to a health care liability action, punitive damages may not exceed the sum of damages awarded for economic and non-economic losses.

(2) DETERMINATION OF AMOUNT.—In determining the amount of punitive damages in a health care liability action, the trier of fact shall consider all relevant evidence, including—

(A) the severity of the harm caused by the conduct of the defendant;

(B) the duration of the conduct or any concealment of the conduct by the defendant;

(C) awards of punitive or exemplary damages to persons similarly situated to the claimant; and

(D) prospective awards of economic and noneconomic losses to persons similarly situated to the claimant.

(e) ATTORNEYS' FEES.—Compensation for reasonable attorneys' fees to be paid by each party in connection

with a health care liability action shall be determined by the court after an evidentiary hearing and prior to final disposition of the action. Attorneys' fees shall be calculated on the basis of an hourly rate or as a percentage of the total damages awarded for economic and noneconomic losses and shall not exceed an amount that would be considered reasonable based on the following:

(1) The time, labor, and skill necessary to properly perform the legal services required by the action.

(2) The novelty and difficulty of the questions involved in the action.

(3) The likelihood, if apparent to the client, that the acceptance of employment with respect to the client's action will preclude other employment by the attorney.

(4) The fee customarily charged in the locality for similar legal services.

(5) The amount involved in the action and the results obtained.

(6) The time limitations imposed by the client or by the circumstances of the action.

(7) The nature and length of the professional relationship between the attorney or attorneys and the client.

(8) The experience, reputation, and ability of the attorney or attorneys performing the services in connection with the action.

(9) Whether the fee for services in connection with the action is fixed or contingent.

SEC. 144. JOINT AND SEVERAL LIABILITY.

(a) IN GENERAL.—With respect to a health care liability action, joint and several liability shall apply—

(1) to the liability of each defendant for damages for economic losses; and

(2) as between persons acting in concert where the concerted action proximately caused the injury for which one or more persons are found liable for damages.

(b) NONECONOMIC DAMAGES.—With respect to a health care liability action, joint and several liability shall not apply to the liability of each defendant for damages for noneconomic losses. A person found liable for damages for noneconomic losses in any such action may—

(1) be found liable, if at all, only for those damages directly attributable to the pro rata share of fault or responsibility of such person for the injury; and

(2) not be found liable for damages attributable to the pro rata share of fault or responsibility of any

other person (without regard to whether that person is a party to the action) for the injury, including any person bringing the action.

SEC. 145. STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Except as provided in subsection (b), no health care liability action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury should reasonably have been discovered, but in no event later than 4 years after the date of the alleged occurrence of the injury.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, no health care liability action may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury should reasonably have been discovered, but in no event later than 4 years after the date of the alleged occurrence of the injury or the date on which the minor attains 8 years of age, whichever is later.

SEC. 146. PREEMPTION.

(a) IN GENERAL.—This part supersedes any State law only to the extent that State law establishes higher payment limits, permits the recovery of a greater amount of damages or the awarding of a greater amount of attor-

neys' fees, or establishes a longer period during which a health care liability action may be initiated.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this part shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976 (28 U.S.C. 1602 et seq.);

(4) preempt State choice-of-law rules with respect to actions brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss an action of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

SEC. 147. EFFECTIVE DATE.

This part shall apply to any health care liability action initiated after the expiration of the 2-year period that begins on the date of the enactment of this Act.

PART III—ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

SEC. 148. GRANTS FOR ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—The Secretary shall make grants to States from amounts appropriated under section 150 for the development and implementation of alternative dispute resolution systems, under such terms as the Secretary may require.

(b) APPLICATION.—

(1) IN GENERAL.—No grant may be made under this section unless an application is submitted to the Secretary. Any such application shall—

(A) be submitted to the Secretary within 1 year after the notification of availability of funds by the Secretary; and

(B) either—

(i) contain a certification by the chief executive officer of the State that, on the date the application is submitted, the State has enacted, adopted, or otherwise has in effect an alternative dispute resolution system; or

(ii) contain a certification by the chief executive officer of the State that, on the date the application is submitted, the State

plans to develop an alternative dispute resolution system.

(2) SUPPORTING DOCUMENTATION.—The certification required—

(A) under paragraph (1)(B)(i) shall be accompanied by supporting documentation, including copies of relevant State statutes, rules, procedures, regulations, judicial decisions, and opinions of the State attorney general; and

(B) under paragraph (1)(B)(ii) shall be accompanied by supporting documentation, including a detailed plan of the alternative dispute resolution system to be developed by the State.

(c) REVIEW OF APPLICATIONS.—Within 90 days after receiving an application under subsection (b), the Secretary shall review and approve the application if, in the determination of the Secretary, the application demonstrates that—

(1) the State has enacted, adopted, or otherwise has in effect an alternative dispute resolution system; or

(2) the State has a plan to develop an alternative dispute resolution system.

(d) AMOUNT OF GRANT.—

(1) IN GENERAL.—The amount of a grant under this section shall be an amount that the Secretary finds reasonable and necessary for the development and implementation of the alternative dispute resolution system of the State.

(2) REDUCTIONS FOR EXPENSES OF SUPPLIES, EQUIPMENT, AND EMPLOYEE DETAIL.—The Secretary may reduce the amount of a grant by—

(A) the fair market value of any supplies or equipment furnished to the recipient by the Secretary;

(B) the amount of pay, allowances, and travel expenses incurred by any officer or employee of the Federal Government when such officer or employee has been detailed to the recipient; and

(C) the amount of any other costs incurred in connection with the detail of an officer or employee as described in subparagraph (B),

when the furnishing of such supplies or equipment or the detail of such an officer or employee is for the convenience, and at the request, of such recipient and for the purpose of carrying out activities under the grant.

(3) OPTION TO REFUSE GRANT.—Not later than 90 days after the Secretary makes a grant under this section to a State, that State may send notice to the Secretary that it refuses the grant. At the time the State sends such notice, the State shall return any amounts paid to it under such grant to the Secretary.

(e) SUPPLEMENTAL GRANTS.—If amounts appropriated for grants under this section remain available because—

(1) a State has notified the Secretary that it refuses the grant made to the State;

(2) a State has notified the Secretary that it does not intend to use the full amount of a grant awarded to the State; or

(3) the amount paid to a State under a grant is reduced, offset, or repaid under subsection (d)(2),

the Secretary shall have the discretion to make supplemental grants to States, to the extent such amounts are available, for the implementation of alternative dispute resolution systems. A grant received by a State under this subsection shall be used by the State to further implement and evaluate the effectiveness of such a system.

(f) RECORDS.—

(1) IN GENERAL.—Each recipient of a grant under this section shall keep such records as the Secretary determines appropriate.

(2) AUDIT AND EXAMINATION OF RECORDS.—The Secretary and the Comptroller General of the United States shall have access to any books, documents, papers, and records of the recipient of a grant under this section, for the purpose of conducting audits and examinations of such recipient that are pertinent to such grant.

(g) REPORTS.—

(1) REPORTS ON COMPLIANCE.—

(A) SUBMISSION OF REPORTS.—Each State shall annually submit a report to the Secretary containing such information as the Secretary may require to determine whether the State is in compliance with the terms of the grant made under this section.

(B) DETERMINATION OF NONCOMPLIANCE.—If, after reviewing the report submitted under subparagraph (A), the Secretary determines that a State receiving a grant under this section is not in compliance with the terms of the grant, the Secretary shall provide the State

with written notice of such determination. Such notice shall specify—

(i) the reasons for the determination of the Secretary;

(ii) that the Secretary will require the State, not later than 60 days after receipt of such notice, to return all funds provided to the State under the grant, unless the State—

(I) takes such corrective action as may be necessary to ensure that the State is in compliance with the terms of the grant; or

(II) requests a hearing under clause (iii); and

(iii) that the State may request a hearing on the record before an administrative law judge under section 554 of title 5, United States Code, concerning the allegations set forth in the notice.

(2) ADDITIONAL REPORTS.—Each State receiving a grant under this section shall, not later than 2 years after the approval of its application for such grant and every 2 years thereafter, prepare and submit to the Commission on National Health Care Ac-

cess and Reform established under section 201 (hereafter in this subtitle referred to as the ''Commission''), the Secretary, and the appropriate committees of Congress, a report and evaluation concerning the alternative dispute resolution systems implemented by the State, including information—

(A) on the effect of such systems on the cost of health care within the State;

(B) on the impact of such systems on the access of individuals to health care within the State; and

(C) on the effect of such systems on the quality of health care provided within the State;

SEC. 149. ESTABLISHMENT OF ADVISORY PANEL.

(a) IN GENERAL.—The Commission shall make recommendations to the Secretary concerning the eligibility, approval, and review requirements for alternative dispute resolution systems described in applications submitted under section 148(b).

(b) ADVISORS.—The Commission shall—

(1) direct the National Advisory Board established under section 202 to assist in carrying out the Commission's activities under this section; or

(2) establish a panel of advisors to assist in carrying out the Commission's activities under this section.

(c) MEMBERS OF THE ADVISORY PANEL.—If the Commission establishes an advisory panel under subsection (b)(2), the members of the advisory panel shall include representatives from each of the following:

(1) Patient advocacy groups.

(2) Groups representing State governments.

(3) Health care provider groups, including organized medicine.

(4) Health care insurers.

(5) Health care employers.

(6) Academic researchers from disciplines such as medicine, economics, law or health services, with expertise in alternative dispute resolution models.

(d) DUTIES OF ADVISORS.—The advisors appointed under paragraph (1) or (2) of subsection (b) shall—

(1) assist in the development of criteria for alternative dispute resolution systems that States must meet to be eligible to receive grants under section 148 and make information on such criteria available to the States to assist such States in preparing applications for grants;

(2) as part of the criteria developed under paragraph (1), require that the alternative dispute resolution systems for which States receive grants under section 148—

(A) support access to health care;

(B) encourage improvements in the quality of care;

(C) enhance the patient-provider relationship;

(D) encourage innovation in health care delivery systems;

(E) provide prompt resolution and fair compensation;

(F) provide predictable outcomes; and

(G) operate efficiently in terms of costs and processes;

(3) provide advice and assistance to representatives from State governments concerning the establishment of alternative dispute resolution systems;

(4) not later than 7 years after the date of enactment of this Act, submit to the Commission, the Secretary, and to the appropriate committees of Congress, a recommendation on the feasibility of a national alternative dispute resolution system; and

(5) perform the duties set forth in part IV.

(e) COMPENSATION.—All members of the advisory panel established under subsection (b)(2) shall be reimbursed by the Commission for travel and per diem expenses in lieu of subsistence expenses during the performance of duties of the Panel in accordance with subchapter I of chapter 57 of title 5, United States Code.

(f) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to an advisory panel established under subsection (b)(2).

(g) PROVISION OF INFORMATION BY THE SECRETARY.—The Secretary shall make available to the advisors appointed under paragraph (1) or (2) of subsection (b) any information concerning the grants made under section 148 that is necessary for such advisors to complete the duties set forth in subsection (d).

SEC. 150. AUTHORIZATION.

(a) IN GENERAL.—There are authorized to be appropriated $250,000,000 for each of the fiscal years 1994, 1995, and 1996, for grants under section 148.

(b) AVAILABILITY OF FUNDS.—Amounts appropriated for grants under section 148 shall remain available until expended.

PART IV—DEMONSTRATION PROJECTS FOR NO-FAULT COMPENSATION PROGRAMS

SEC. 151. DEMONSTRATION PROJECTS FOR NO-FAULT COMPENSATION PROGRAMS.

(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to private entities for the development and implementation of demonstration no-fault compensation programs in the private sector.

(b) APPLICATION.—To be eligible to receive a grant under this section a private entity shall prepare and submit to the Secretary an application at such time, in such form, and containing such information as the Secretary may require including a description of the no-fault compensation program that the private entity intends to develop or implement.

(c) REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary shall review and approve applications received under subsection (b) in accordance with recommendations made by the Commission with the advice of the advisors appointed under section 149(b).

(d) AMOUNT OF GRANT.—The amount of a grant to a private entity under this section shall be an amount that the Secretary finds reasonable and necessary for the development and implementation of the no-fault compensation program.

(e) DUTIES OF ADVISORS.—

(1) IN GENERAL.—The advisors appointed under section 149(b) shall—

(A) develop criteria for no-fault compensation programs in the private sector that private entities must meet to be eligible to receive grants under this section; and

(B) make information on such criteria available to the private entities to assist such entities in preparing applications for grants.

(2) CRITERIA.—As part of the criteria developed under paragraph (1), the advisors shall require that the no-fault compensation programs for which States receive grants under this section—

(A) provide that health care providers offer their patients a no-fault compensation scheme in exchange for a waiver of common law tort liability for all injuries;

(B) provide that patients are fully informed of the common law tort rights they are surrendering and the no-fault benefits they are eligible to receive; and

(C) provide that the health care facility operate an effective quality assurance program, including measures for reporting and account-

ability for all adverse events identified through this claims process.

(f) REPORTS AND RECOMMENDATIONS.—

(1) REPORTS BY RECIPIENTS OF GRANTS.—Not later than 2 years after the approval of its application, each private entity that is a grant recipient shall prepare and submit a report to the Commission, the Secretary, and the appropriate committees of Congress, which contains—

(A) an analysis of the feasibility and desirability of developing and implementing no-fault compensation programs; and

(B) a recommendation for legislation on the development and implementation of no-fault compensation programs.

(2) RECOMMENDATIONS.—The Commission shall review the reports made by grant recipients pursuant to paragraph (1) and make recommendations to the Secretary regarding proposals for legislation to develop and implement national no-fault compensation programs.

(g) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated for grants under this section

$20,000,000 for each of the fiscal years 1994, 1995, and 1996.

(2) AVAILABILITY OF FUNDS.—Amounts appropriated for grants under this section shall remain available until expended.

Subtitle F—Joint Ventures

SEC. 161. AMENDMENT OF THE NATIONAL COOPERATIVE RESEARCH ACT OF 1984.

(a) DEFINITIONS.—Section 2(a) of the National Cooperative Research Act of 1984 (15 U.S.C. 4301(a)) is amended by adding at the end the following new paragraph:

''(7) The term 'joint health care provider venture' means a group of activities, as determined by the Commission on National Health Care Access and Reform (established under section 201 of the BasiCare Health Access and Cost Control Act), by 2 or more hospitals for the provision or delivery of health care services.''.

(b) EXCLUSIONS.—Section 2(b) of such Act (15 U.S.C. 4301(b)) is amended—

(1) in the matter preceding paragraph (1) by striking ''excludes'' and inserting ''and the term 'joint health care provider venture' exclude''; and

(2) in paragraph (1) by striking ''conduct the research and development that is'' and inserting ''carry out''.

(c) TECHNICAL AMENDMENTS.—(1) Section 3 of such Act (15 U.S.C. 4302) is amended by inserting ''or joint health care provider venture'' after ''joint research and development venture''.

(2) Section 4 of such Act (15 U.S.C. 4303) is amended in subsections (a)(1), (b)(1), (c)(1), and (e) by inserting ''or joint health care provider venture'' after ''joint research and development venture'' each place it appears.

(3) Section 5(a) of such Act (15 U.S.C. 4304(a)) is amended in the matter preceding paragraph (1) by inserting ''or joint health care provider venture'' after ''joint research and development venture''.

(4) Section 6 of such Act (15 U.S.C. 4305) is amended—

(A) in the heading by striking ''RESEARCH AND DEVELOPMENT'';

(B) in subsections (a), (d)(2), and (e) by inserting ''or joint health care provider venture'' after ''joint research and development venture'' each place it appears; and

(C) in the first sentence of subsection (a) by inserting ''(or in the case of a joint health care pro-

vider venture, the date of enactment of the BasiCare Health Access and Cost Control Act)'' after ''this Act''.

TITLE II—LONG-TERM REFORMS

Subtitle A—Establishment of Commission and Advisory Board

SEC. 201. THE COMMISSION ON NATIONAL HEALTH CARE ACCESS AND REFORM.

(a) ESTABLISHMENT.—There is established an independent commission to be known as the Commission on National Health Care Access and Reform (hereinafter referred to as the ''Commission'').

(b) DUTIES.—The Commission shall carry out the duties specified for it in this title.

(c) APPOINTMENT.—

(1) COMPOSITION.—

(A) SIZE AND MANNER OF APPOINTMENT.—The Commission shall consist of—

(i) five members to be appointed by the President, by and with the advice and consent of the Senate, one of whom shall, at the time of appointment, be designated as Chairperson of the Commission;

(ii) two members to be appointed by the Speaker of the House of Representa-

tives upon the recommendations of the Majority Leader and Minority Leader of the House of Representatives; and

(iii) two members to be appointed by the President pro tempore of the Senate upon the recommendations of the Majority Leader and Minority Leader of the Senate.

(B) POLITICAL AFFILIATION.—At no time shall more than three of the members appointed by the President, one of the members appointed by the Speaker of the House of Representatives, or one of the members appointed by the President pro tempore of the Senate be members of the same political party.

(C) MEMBERSHIP QUALIFICATIONS.—The membership of the Commission shall consist of individuals who are of recognized standing and distinction and who possess the demonstrated capacity to discharge the duties imposed on the Commission, and shall include persons possessing substantial knowledge or expertise in health care delivery, health care insurance, or health care economics. No individual who is otherwise an officer or full-time employee of the United States shall serve as a member of the Commis-

sion. No member while serving on the Commission may receive financial gain from direct investments, employment or associations from any entity with demonstrable financial interest in matters over which the Commission has jurisdiction.

(D) CHAIRPERSON.—The Chairperson of the Commission shall designate a member of the Commission to act as Vice Chairperson of the Commission.

(E) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

(F) TERM.—Members of the Commission shall be appointed for a term of 5 years, except that with respect to the members first appointed—

(i) the Chairperson and 2 members, 1 each appointed under clauses (ii) and (iii) of paragraph (1)(A), respectively, shall be appointed for a term of 5 years;

(ii) 3 members, 1 each appointed under clauses (i), (ii) and (iii) of paragraph (1)(A), respectively, shall be appointed for a term of 4 years; and

(iii) the remaining members shall be appointed for a term of 3 years.

(G) VACANCY.—A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment, but the individual appointed shall serve only for the unexpired portion of the term for which the individual's predecessor was appointed.

(2) EFFECTIVE DATE.—Appointments to the Commission shall be made no later than 90 days after the date of enactment of this Act.

(d) MEETINGS.—The Commission shall meet at the call of the Chairperson, or at the call of a majority of the members of the Commission; but meetings shall not be held less frequently than once in each calendar month which begins after a majority of the membership of the Commission has been appointed.

(e) HEARINGS.—In carrying out its duties under this section, the Commission, or any duly authorized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters with respect to which it has a responsibility under this title, as the Commission or such committee may deem advisable. The Chairperson of the

Commission or any member authorized by the Chairperson may administer oaths or affirmations to witnesses appearing before the Commission or before any committee thereof.

(f) PAY AND TRAVEL EXPENSES.—

(1) PAY.—

(A) MEMBERS.—Each member, other than the Chairperson, shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

(B) CHAIRPERSON.—The Chairperson shall be paid for each day referred to in subparagraph (A) at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

(2) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in lieu of subsist-

ence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(g) STAFF.—

(1) APPOINTMENT.—Subject to paragraphs (2) and (3), the Chairperson, with the approval of the Commission, may appoint and fix the pay of additional personnel.

(2) INAPPLICABILITY OF CIVIL SERVICE LAWS.—The Chairperson may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, except that an individual so appointed shall receive pay—

(A) not less than 120 percent of the minimum rate of basic pay payable for GS–15 of the General Schedule, and

(B) no greater than the rate of basic pay payable for level IV of the executive schedule.

(3) DETAIL OF PERSONNEL FROM FEDERAL AGENCIES.—Upon request of the Chairperson, the head of any Federal department or agency may de-

tail any of the personnel of that department or agency to the Commission to assist the Commission in carrying out its duties under this title.

(4) FEDERAL AGENCY ASSISTANCE.—The Comptroller General of the United States, the Secretary of Health and Human Services, and the Administrator of General Services shall provide assistance on a reimbursable basis, including the detailing of employees, to the Commission in accordance with an agreement entered into with the Commission.

(h) OTHER AUTHORITY.—

(1) CONSULTANT SERVICES.—The Commission may procure by contract, to the extent funds are available, the temporary or intermittent services of experts or consultants pursuant to section 3109 of title 5, United States Code.

(2) PROPERTY MATTERS.—The Commission may lease space and acquire personal property to the extent funds are available.

SEC. 202. NATIONAL ADVISORY BOARD.

(a) APPOINTMENT.—The Commission shall provide for appointment of a National Advisory Board (hereinafter referred to as the ''Board'') to advise the Commission on its activities.

(b) MEMBERSHIP.—The Board shall consist of 15 members who are representatives of employers, unions, health care providers, health care carriers, consumer organizations, State health programs, and public health professionals, as well as the general public. Such members shall serve for terms of 3 years, except that, in the initial appointment, 5 members shall be each appointed for terms of 1 year, 2 years, and 3 years.

(c) VACANCIES.—

(1) IN GENERAL.—The Commission shall fill any vacancy in the membership of the Board in the same manner as the original appointment. The vacancy shall not affect the power of the remaining members to execute the duties of the Board.

(2) VACANCY APPOINTMENTS.—Any member appointed to fill a vacancy shall serve for the remainder of the term for which the predecessor of the member was appointed.

(3) REAPPOINTMENT.—The Commission may reappoint an appointed member of the Board for a second term in the same manner as the original appointment.

(d) CHAIRPERSON AND VICE CHAIRPERSON.—The Board shall select a Chairperson and a Vice Chairperson from among the members of the Board.

(e) COMPENSATION.—All members of the Board and the committees established under subsection (h) shall be reimbursed by the Commission for travel and per diem in lieu of subsistence expenses during the performance of duties of the Board in accordance with subchapter I of chapter 57 of title 5, United States Code.

(f) FACA NOT APPLICABLE.—The provisions of the Federal Advisory Committee Act shall not apply to the Board.

(g) DUTIES.—As directed by the Commission, the Board shall undertake such projects as the Commission may deem necessary. Such projects may include site visits and studies that are concerned with issues of access to health care services, utilization of health care services, consumer participation and satisfaction in the provision of health care services, education of health personnel, medical practice, medical technology, quality of insurance plans and health care delivery, and malpractice liability. The Board shall not undertake studies, visits, or projects, nor shall it issue recommendations, except at the request of the Commission.

(h) COMMITTEES.—The Board shall create such committees (composed of Commission members and others as appointed by the Chairperson) as necessary to enable the Board to meet its responsibilities and functions.

SEC. 203. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Commission such funds as are necessary to carry out its duties under this title. Such funds shall remain available until expended.

Subtitle B—Reform and Standardization of Private Insurance

SEC. 211. DEFINING GOALS AND GUIDELINES OF COMMISSION.

(a) DEFINING GOALS.—In carrying out the responsibilities assigned to it under this Act, the Commission shall at all times seek to—

(1) improve access to basic health coverage and services;

(2) control the cost of health care coverage and services;

(3) safeguard the quality of health care services;

(4) assure equity in the availability and cost of health care coverage and services; and

(5) minimize administrative complexity and duplication in the health care system.

(b) GUIDELINES.—In carrying out the responsibilities assigned to it under this Act, the Commission shall in developing or evaluating any health care proposal or modification be guided by the anticipated effect on—

(1) the cost of health care to medical consumers;

(2) the quality of health care services;

(3) access to health care services;

(4) the financial viability of health care providers;

(5) the financial viability of health care carriers;

(6) the provision of health benefits to employees by employers; and

(7) the administrative complexity of the health care system.

(c) CONSULTATIONS.—In carrying out the responsibilities assigned to it under this Act, the Commission shall seek out and consider recommendations from a broad range of interested individuals and organizations, including organizations representing health care consumers, health care providers, health care carriers, representatives of State health programs, public health professionals, and the general public.

SEC. 212. DEVELOPMENT AND SUBMISSION OF LEGISLATIVE PROPOSAL.

(a) IN GENERAL.—By not later than January 1, of the 2nd year following the date of enactment of this Act, the Commission shall develop and submit to Congress a legislative proposal which provides for the following:

(1) BASICARE BENEFITS PACKAGE.—A uniform national health benefits package (hereinafter referred to as the ''BasiCare benefits package'') specifying minimum benefits applicable to all carriers which meets the requirements of section 214.

(2) INSURANCE RESPONSIBILITIES UNDER BASICARE.—A national health care insurance reform plan which meets the requirements of section 215 and which shall apply to all carriers selling health insurance in the United States.

(3) ESTABLISHMENT OF BASICARE BASE PREMIUM RATE.—A base premium rate (hereinafter referred to as the ''BasiCare base premium rate'') to apply to the BasiCare benefits package, which meets the requirements of section 216.

(4) EMPLOYER RESPONSIBILITIES UNDER BASICARE.—Employer responsibilities to offer the BasiCare health benefit plan as described in section 217.

(5) INDIVIDUAL RESPONSIBILITIES UNDER BASICARE.—Individual responsibilities to obtain the BasiCare health benefit plan coverage as described in section 218.

(6) SELF-INSURED REQUIREMENTS.—Self-insured plan requirements with respect to certification as described in section 219.

(7) PROVIDER RESPONSIBILITIES UNDER BASICARE.—Provider responsibilities under the BasiCare health benefit plan as described in section 220.

(8) TREATMENT OF MANAGED CARE PLANS.—Federal standards for managed care plans as described in section 221 and preemption of State provisions relating to such plans, as described in section 222.

(9) LOW-INCOME ASSISTANCE.—A program to provide low-income individuals and families—

(A) an orderly transfer from medicaid program coverage under title XIX of the Social Security Act to BasiCare health benefit plan coverage, and

(B) financial assistance in obtaining BasiCare health benefit plan coverage,

as specified in subtitle C.

(b) CONSIDERATION.—The legislative proposal described in subsection (a) shall be considered by the Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

(c) EFFECTIVE DATE OF IMPLEMENTATION.—The provisions of the recommendation shall become effective on January 1 of the year following the year of the date of approval of the Commission's recommendation (unless such period of time is less than 9 months, in which case such provisions shall become effective on January 1 of the second year following the date of approval of the Commission's recommendation).

SEC. 213. CONTINUING DUTIES AND RESPONSIBILITIES OF THE COMMISSION.

(a) PERIOD FOR RESUBMISSION OF BASICARE PACKAGE AND BASE RATE IN CASE OF NONAPPROVAL.—If the recommendation of the Commission submitted under section 212 is not approved by Congress in a year, the Commission shall by not later than January 1 of each year thereafter, for a period not to exceed 2 years (unless such recommendation is approved in a year) submit a new recommendation to Congress subject to the guidelines and requirements of this title.

(b) CONTINUING REVIEW OF BASICARE BENEFITS PACKAGE AND BASICARE BASE PREMIUM RATE.—

(1) MODIFICATIONS IN BASICARE BENEFITS PACKAGE.—The Commission may by not later than September 30 of any year following the effective date of implementation of the Commission's rec-

ommendation under section 212, subject to the guidelines and goals applicable to its initial recommendation, publish in the Federal Register revisions to the BasiCare benefits package, which revisions shall become effective on January 1 of the immediately following calendar year unless rescinded by Congress.

(2) MODIFICATIONS TO VARIATIONS IN BASICARE BASE PREMIUM RATE.—The Commission may by not later than September 30 of any year following the effective date of implementation of the Commission's recommendation under section 212, subject to the guidelines and goals applicable to its initial recommendation, publish in the Federal Register revisions to any variations provided in the BasiCare base premium rate, which revisions shall become effective on January 1 of the immediately following calendar year unless rescinded by Congress.

(c) ESTABLISHMENT OF ANNUAL ALLOWABLE RATES OF INCREASE IN BASICARE PREMIUM RATES.—The Commission shall by not later than September 30 of each year following the effective date of implementation of the Commission's recommendation under section 212, subject to the guidelines and goals applicable to its initial

recommendation, publish in the Federal Register a percentage figure for a single allowable rate of increase in BasiCare premiums to become effective on January 1 of the immediately following calendar year unless such percentage figure is modified or rescinded by Congress. Such rate of increase shall be binding on all carriers offering benefits covered under the BasiCare benefits package, as provided in section 215.

(d) OVERSIGHT OF PROVIDER PARTICIPATION.—

(1) IN GENERAL.—The Commission shall conduct ongoing oversight of provider response to the imposition of annual limits in the allowable rate of increase in BasiCare premiums, as provided in this Act. The findings of such oversight shall be expressed in annual reports to Congress.

(2) CONSIDERATIONS.—Matters to be examined in such oversight shall include, but are not limited to, the following:

(A) The incidence of participation (or nonparticipation) of health care providers in BasiCare health benefit plans.

(B) The effect of such participation (or nonparticipation) on the availability and affordability of health care services to health care consumers.

(C) The extent to which the incidence of nonparticipation in BasiCare health benefit plans may vary according to professional specialty or region.

(3) OPTION FOR PARTICIPATION REQUIREMENTS.—At any time following the standardization of the BasiCare health benefit plan under this Act, the Commission may submit to Congress a legislative proposal providing for such participation requirements as the Commission may deem necessary to assure a level of provider participation in BasiCare health benefit plans sufficient to assure affordable access to quality health care services by BasiCare enrollees.

(4) CONGRESSIONAL CONSIDERATION.—Any proposal made to Congress under this subsection shall be considered by Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

(e) OVERSIGHT OF SUPPLEMENTAL HEALTH INSURANCE MARKET.—

(1) IN GENERAL.—The Commission shall, upon implementation of the Commission's recommendations under section 212, commence an ongoing assessment of the condition of the supplemental health

insurance market for insurance benefits which are beyond the scope of the BasiCare benefits package. The findings of such assessment shall be transmitted in annual reports to the appropriate committees of Congress.

(2) CONSIDERATIONS.—Matters to be addressed in such assessment shall include, but not be limited to—

(A) the rate of cost growth in the supplemental market, and the extent to which such growth may be contributing to growth in national health care expenditures;

(B) the affordability and availability of supplemental policies to employers, families, and individuals;

(C) the extent to which the terms and cost of coverage vary among beneficiaries based on health and claims status;

(D) the value of supplemental policies to beneficiaries, as measured by loss ratios;

(E) the extent of questionable marketing practices, such as misrepresentation of policy benefits or provisions, or the selling of policies that duplicate existing coverage; and

(F) the extent to which State insurance regulation is addressing perceived problems in the supplemental market.

(3) RECOMMENDATION TO CONGRESS.—No later than January 1 of the second year following the effective date of implementation of the Commission's recommendations under this title, the Commission shall include in its annual report to Congress (under this subsection) a recommendation regarding the advisability of Federal regulation of the supplemental health insurance market. If the Commission's recommendation is that such regulation is needed, the Commission shall prepare and submit to Congress draft legislation to carry out the terms of such regulation as it may deem necessary.

(4) SUBSEQUENT RECOMMENDATIONS.—At any time following submission of its recommendation to Congress under paragraph (3), the Commission may, based on the findings of its continuing assessment under paragraphs (1) and (2), submit additional recommendations or draft legislation to Congress regarding action it may consider advisable relative to the supplemental market.

(5) CONGRESSIONAL CONSIDERATION.—Proposals made to Congress under this subsection shall be

considered by Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

(f) SAFEGUARDING QUALITY OF HEALTH CARE.—

(1) ANNUAL REPORT.—The Commission shall by no later than January 1 of each year following the date of enactment of this Act, submit an annual report to Congress assessing the quality of health care in the United States, and outlining areas of significant progress or decline in the delivery of or accessibility to health care. In preparing such reports, the Commission shall conduct such studies, hearings, or other evaluations as it deems necessary to accomplish a comprehensive and continuing evaluation of health care quality in the United States.

(2) CONTRACTS FOR PROVISION OF INFORMATION TO CONSUMERS REGARDING QUALITY OF HEALTH CARE SERVICES AND INSURANCE.—The Commission shall enter into contracts with the applicable regulatory authority in each State, or such public or private nonprofit entities as the Commission deems necessary, for the collection and dissemination to consumers of information regarding the quality and cost-effectiveness of services provided by health care providers and carriers of BasiCare

health benefit plans in the State. Such information shall include—

(A) the degree to which a plan's practice patterns agree with what is known about appropriate and inappropriate approaches to health care,

(B) outcome rates for patients with particular conditions, and

(C) patient satisfaction with various aspects of a plan's performance.

(3) REQUIREMENT TO CONSIDER HEALTH CARE QUALITY DATA.—Information regarding health care quality obtained through the activities described in this subsection shall be considered and incorporated by the Commission in carrying out the other continuing duties and responsibilities assigned to it under this section including setting annual premium limits and other rates as provided in this title.

(g) UNIFORM CLAIMS FORMS AND ELECTRONIC PROCESSING.—

(1) IN GENERAL.—The Commission shall develop in consultation with entities offering health insurance, health care providers, and the Secretary, a uniform claims form to be used by both private

health plans and by the medicare program under title XVIII of the Social Security Act.

(2) APPLICATION AND REVISION.—The Commission shall by no later than 1 year after the effective date of implementation of the Commission's recommendation under section 212, require that the uniform claims form developed under paragraph (1), be utilized by all carriers offering benefits covered under the BasiCare benefits package and under title XVIII of the Social Security Act. The Commission shall revise such form, as necessary, to reflect changes in the health care insurance market.

(3) UNIFORM REPORTING STANDARDS.—In developing the claims form under paragraph (1), the Commission in consultation with the entities described in such paragraph, shall develop standards for uniform reporting (while preserving individual patient identity) concerning—

(A) the types and amounts of required health services provided; and

(B) the costs of such facilities providing such services.

The Commission shall periodically collect, analyze, and disseminate information received under this paragraph.

(4) UNIVERSAL ELECTRONIC PAYMENT AND BILLING CARD.—In conjunction with development of the standard claims form under paragraph (1), the Commission shall develop, and all private and public health insurance programs shall be required to participate in, a program to provide a universal health insurance card to every individual or family which shall be accepted by all health care providers for purposes of payment and billing. Such cards shall be imprinted electronically with necessary and appropriate information concerning coverage and billing, and to the maximum extent practicable, with information to assist in the management of a uniform system of computerized patient records.

(h) LONG-TERM DISPOSITION OF MEDICAID BENEFITS AND PROGRAM.—

(1) IN GENERAL.—At any time following the effective date of implementation of the Commission's recommendation under section 212, the Commission may submit to Congress a proposed plan for long-term disposition of any benefits of the medicaid program not covered under or subsumed by the BasiCare benefits package.

(2) PROPOSED PLAN.—In preparing a proposed plan described in paragraph (1), the Commission

shall consult with representatives of State medicaid programs, and shall follow the goals and guidelines described in section 211.

(3) CONGRESSIONAL CONSIDERATION.—Proposals made to Congress under this subsection shall be considered by the Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

(4) PERIOD FOR RESUBMISSION OF PROPOSAL.—If the recommendation of the Commission submitted under this subsection is not approved by Congress in a year, the Commission shall by not later than January 1 of each year thereafter, for a period not to exceed 2 years (unless such recommendation is approved in a year) submit a new recommendation to Congress subject to the guidelines and requirements of this title.

(i) ASSIMILATION OF MEDICARE INTO BASICARE SYSTEM.—

(1) IN GENERAL.—The Commission shall by no later than January 1 of the fifth year following the effective date of implementation of the Commission's recommendation under section 212, submit to the Congress draft legislation providing for the assimilation of the medicare program under title XVIII of

the Social Security Act into the BasiCare system. The Commission shall include with such draft legislation, an accompanying report detailing and explaining the provisions of such draft legislation.

(2) CONGRESSIONAL CONSIDERATION.—Proposals made to Congress under this subsection shall be considered by Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

(3) PERIOD FOR RESUBMISSION OF PROPOSAL.—If the proposal of the Commission submitted under this subsection is not approved by Congress in a year, the Commission shall by not later than January 1 of each year thereafter, for a period not to exceed 2 years (unless such recommendation is approved in a year) submit a new proposal to Congress subject to the guidelines and requirements of this title.

(j) ASSIMILATION OF OTHER PROGRAMS INTO BASICARE SYSTEM.—

(1) IN GENERAL.—The Commission shall by no later than January 1 of the fifth year following the effective date of implementation of the Commission's recommendation under section 212, submit to the

Congress draft legislation providing for the assimilation into the BasiCare system of—

(A) the veterans health care program under chapter 17 of title 38, United States Code,

(B) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code,

(C) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), and

(D) the Federal employees program under chapter 89 of title 5, United States Code.

The Commission shall include with such draft legislation, an accompanying report detailing and explaining the provisions of such draft legislation.

(2) CONGRESSIONAL CONSIDERATION.—Proposals made to Congress under this subsection shall be considered by Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

(3) PERIOD FOR RESUBMISSION OF PROPOSAL.—If the proposal of the Commission submitted under this subsection is not approved by Con-

gress in a year, the Commission shall by not later than January 1 of each year thereafter, for a period not to exceed 2 years (unless such recommendation is approved in a year) submit a new proposal to Congress subject to the guidelines and requirements of this title.

(k) OVERSIGHT OF SUCH UNCOMPENSATED CARE AS MAY REMAIN.—To the extent it deems necessary, and to the extent practicable, the Commission may provide to Congress recommendations for the establishment of national or regional compensation pools, or other mechanisms, for the payment of providers who furnish BasiCare-covered services to individuals who, through choice or inadvertence, fail to secure BasiCare coverage as provided in this Act.

(l) MEDICAL EDUCATION ASSISTANCE.—In conjunction with the duties assigned to it under section 212 of this Act, and in conjunction with its proposal to assimilate the medicare program under title XVIII of the Social Security Act into BasiCare under subsection (i) of this section, the Commission shall consider and develop methods to assure support for academic health centers and the provision of quality training to health professionals.

(m) CERTIFICATION.—

(1) IN GENERAL.—The Commission shall require that no health benefit plan may be offered by a carrier under section 215 or by an employer under section 217 or 219 on or after the effective date of implementation of the Commission's recommendation under this title, unless the plan has been certified by the Commission (in accordance with such procedures as the Commission establishes) as qualifying as a BasiCare health benefit plan. The Commission shall enter into an agreement with the applicable regulatory authority of each State, or such public or private nonprofit entities as the Commission deems necessary, to provide for the administration of such certification under this subsection.

(2) LOOK-BEHIND AUTHORITY.—If the Commission determines that a health benefit plan does not qualify on or after the effective date specified in paragraph (1), no coverage may be provided under the plan to individuals not enrolled as of the date of the determination, and the plan may not be continued for plan years beginning after the date of such determination until the Commission determines that such plan so qualifies.

(3) NONAPPLICATION TO SUPPLEMENTAL INSURANCE.—The provisions described in this sub-

section shall apply only to coverage for benefits equivalent to the BasiCare health benefit plan and do not apply to other health benefits.

(n) OVERSIGHT OF PRESCRIPTION DRUGS.—

(1) IN GENERAL.—No later than January 1 of the second year following the effective date of implementation of the Commission's recommendations under this title, the Commission shall submit to Congress a report regarding the advisability of Federal regulation of the costs of prescription drugs in order to maintain the affordability of the BasiCare benefits package. If the Commission's recommendation is that such regulation is needed, the Commission shall prepare and submit to Congress draft legislation to carry out the terms of such regulation as it may deem necessary.

(2) CONGRESSIONAL CONSIDERATION.—Proposals made to Congress under this subsection shall be considered by Congress under the procedures for consideration of an ''approval resolution'' as described in subtitle D.

SEC. 214. BASICARE BENEFITS PACKAGE.

(a) CRITERIA.—In preparing the BasiCare benefits package described in section 212(a)(1), the Commission shall, subject to the requirements of this title, develop and

recommend the BasiCare benefits package as it deems appropriate, adhering to the goals and guidelines described in this subtitle. The BasiCare benefits package developed and recommended by the Commission shall at a minimum provide for—

(1) basic hospitalization coverage;

(2) basic outpatient services;

(3) prescription drugs (subject to reasonable cost-sharing);

(4) protection against catastrophic out-of-pocket costs;

(5) coverage against extraordinary long-term care costs; and

(6) coverage for preventive care services of significant proven and recognized value in averting serious and costly medical conditions.

(b) UNIFORMITY.—

(1) IN GENERAL.—Subject to the exceptions described in paragraph (2), the BasiCare benefits package recommended by the Commission shall provide for uniform national deductibles, copayments, and benefit applications and standards.

(2) LIMITED VARIATION ALLOWED.—In order to accommodate systems for providing health care in a managed system, the Commission may provide for

variations in the structure of BasiCare cost-sharing requirements for such systems, but only to the extent such variations do not significantly compromise the national uniformity of a single BasiCare benefits package.

(c) FLEXIBILITY REGARDING LONG-TERM CARE.—

(1) MODIFIED BENEFIT PLAN FOR MEDICARE BENEFICIARIES.—The Commission may include in its proposal under section 212 provisions for the establishment of a modified BasiCare long-term care benefits plan for persons currently enrolled in the medicare program under title XVIII of the Social Security Act. If the Commission includes such a plan, the plan shall—

(A) consist only of long-term care benefits included in the BasiCare benefits package, and

(B) be subject to the rules and requirements applicable to the BasiCare health benefit plan under this title, except as may be modified by the Commission in its proposal to Congress under section 212.

(2) CONTINUITY OF LONG-TERM CARE COVERAGE.—The Commission may include in its proposal under section 212 such special provisions as it

may deem necessary to assure portability of coverage consistent with the requirements of section 215.

(3) INTERACTION WITH OTHER PROGRAMS.—The Commission may include such provisions as it deems necessary to coordinate BasiCare long-term care coverage with coverage provided under the medicare program under title XVIII of the Social Security Act, and with coverage provided by the medicaid program under title XIX of the Social Security Act, as modified by the terms of this Act.

(d) PREFERENCE FOR COPAYMENTS IN COST-SHARING.—To the extent practicable, the Commission shall employ copayments rather than deductibles in providing for such cost-sharing requirements as may be included in the BasiCare benefits package under this section.

SEC. 215. INSURANCE RESPONSIBILITIES UNDER BASICARE.

(a) IN GENERAL.—In developing the legislative proposal described in section 212(a)(2), the Commission shall provide that the requirements of this section are incorporated as part of its recommendation for national health care insurance reform.

(b) GENERAL REQUIREMENT.—Each carrier shall offer the BasiCare health benefit plan as specified in this section.

(c) PREEMPTION OF STATE MANDATED BENEFIT LAWS.—To the extent that laws of any State or local government regulate or otherwise provide any requirement relating to the benefits to be provided under contracts or policies of insurance issued to, or under, a BasiCare health benefit plan, such laws are preempted.

(d) NONDUPLICATION OF BASICARE.—Health benefit plans may be issued for benefits other than those covered by the BasiCare benefits package described in section 214, but no health benefit plans may be offered by any carrier in any State which duplicate, either in whole or in part, the benefits described in the BasiCare benefits package.

(e) NONDISCRIMINATION BASED ON HEALTH STATUS.—

(1) IN GENERAL.—BasiCare health benefit plans offered by carriers may not deny, limit, or condition the coverage under (or benefits of) the plan based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS FOR ALL SERVICES.—BasiCare health benefit plans provided by carriers may not exclude or otherwise discourage coverage with respect to

services related to treatment of a preexisting condition.

(f) REGISTRATION WITH APPLICABLE REGULATORY AUTHORITY.—

(1) IN GENERAL.—Each carrier shall register with the applicable regulatory authority for each State in which it issues or offers health benefit plans.

(2) NO PREEMPTION OF STATE INFORMATION REQUIREMENTS.—Nothing in paragraph (1) shall be construed as preventing the applicable regulatory authority from requiring, in the case of BasiCare carriers that are not self-insurance carriers, such additional information in conjunction with, or apart from, the registration required under paragraph (1) as the applicable regulatory authority may be authorized to require under State law.

(g) GUARANTEED ISSUE.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a carrier that offers a BasiCare health benefit plan (including a reinsurance plan) to groups or individuals located in a community must offer the same plan to any other group or individual located in the community, and shall participate in a program developed by the Commis-

sion for assigning high-risk groups or individuals among all such carriers.

(2) TREATMENT OF HEALTH MAINTENANCE ORGANIZATIONS.—

(A) GEOGRAPHIC LIMITATIONS.—A health maintenance organization may deny coverage under a BasiCare health benefit plan to an individual or group whose members are located outside the service area of the organization, but only if such denial is applied uniformly without regard to health status or insurability.

(B) SIZE LIMITS.—A health maintenance organization may apply to the applicable regulatory authority to cease enrolling new groups or individuals in its BasiCare health benefit plan (or in a geographic area served by the plan) if it can demonstrate that its financial or administrative capacity to serve previously enrolled groups and individuals (and additional individuals who will be expected to enroll because of affiliation with such previously enrolled groups) will be impaired if it is required to enroll new groups or individuals.

(3) GROUNDS FOR REFUSAL TO ISSUE OR RENEW.—

(A) IN GENERAL.—A carrier may refuse to issue or renew or terminate a BasiCare health benefit plan under this part only for—

(i) nonpayment of premiums,

(ii) fraud or misrepresentation, and

(iii) failure to meet minimum participation rates (consistent with subparagraph (B)).

(B) MINIMUM PARTICIPATION RATES.—A carrier may require, with respect to an employment-related group BasiCare health benefit plan, that a minimum percentage of full-time employees eligible to enroll under the plan be enrolled, so long as such percentage is enforced uniformly for all employment groups of comparable size.

(h) MINIMUM PLAN PERIOD.—A carrier may not offer, or issue a BasiCare health benefit plan with a term of less than 12 months.

(i) GUARANTEED RENEWABILITY.—

(1) IN GENERAL.—

(A) GENERAL RULE.—Subject to the succeeding provisions of this subsection, a carrier shall ensure that a BasiCare health benefit plan issued to a group or individual be renewed, at

the option of the policyholder, unless the plan is terminated for the reasons specified in subsection (h)(3) (A) or under subparagraph (B).

(B) TERMINATION OF BUSINESS.—A carrier need not renew a BasiCare health benefit plan with respect to such a policyholder if the carrier—

(i) is terminating provision of all health insurance in the community; and

(ii) provides notice to the policyholder covered under the plan of such termination at least 90 days before the date of expiration of the plan.

In the case of such a termination, the carrier may not provide for issuance of any health benefit plan in such community during the 5-year period beginning on the date of termination of such block of business.

(C) CONSTRUCTION RESPECTING ADDITIONAL STATE DISCLOSURE REQUIREMENTS.—Subparagraph (B)(ii) shall not be construed as preventing the applicable regulatory authority from specifying the information to be included in the notice under such subparagraph or in re-

quiring such notice to be provided at an earlier date.

(2) NOTICE AND SPECIFICATION OF RATES AND ADMINISTRATIVE CHANGES.—

(A) NOTICE.—A carrier offering BasiCare health benefit plans shall provide for notice, at least 30 days before the date of expiration of the health benefit plan, of the terms for renewal of the plan. Except with respect to rates and administrative changes, the terms of renewal (including benefits) shall be the same as the terms of issuance.

(B) RENEWAL RATES SAME AS ISSUANCE RATES.—The carrier may change the terms for such renewal, but the premium rates charged with respect to such renewal shall be the same as that for a new issue.

(C) RATES CANNOT CHANGE MORE OFTEN THAN MONTHLY.—

(i) IN GENERAL.—A carrier may not change the premium rates established with respect to BasiCare health benefit plans offered in a community more often than monthly.

(ii) APPLICATION OF NEW RATES TO SPECIFIC PLANS.—With respect to a BasiCare health benefit plan which becomes effective in a month, the carrier shall ensure that the premium rate established under clause (i) for that month shall apply to such plan for all months during the 12-month period beginning with that month. In the case of a plan renewal which is effective for a 12-month period beginning with a month, the premium rate established under clause (i) with respect to that month shall apply to all months during 12-month renewal period.

(3) PERIOD OF RENEWAL.—The period of renewal of each health benefit plan offered by a carrier shall be for a period of not less than 12 months.

(j) COMMUNITY RATING.—

(1) IN GENERAL.—A carrier may not charge premium rates for BasiCare health benefit plans in excess of the average per capita cost of providing such coverage to all individuals covered under BasiCare policies issued by that carrier in a community. A BasiCare health benefit plan meeting such

criteria will be considered ''actuarially certified'' for purposes of this subsection.

(2) ACTUARIALLY CERTIFIED DEFINED.—A BasiCare health benefit plan is considered to be ''actuarially certified'' if there is a written statement by a member of the American Academy of Actuaries or other individual acceptable to the applicable regulatory authority that a carrier is in compliance with this section, based upon the individual's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the carrier in establishing premium rates for applicable health benefit plans.

(k) ADJUSTMENTS TO COMMUNITY RATING.—

(1) IN GENERAL.—A BasiCare health benefit plan offered by a carrier to a group or individual may provide for an adjustment to the average community rate based on the age of covered individuals. Any such adjustment shall be applied by the carrier consistently to all policyholders, and no other adjustments shall be permitted.

(2) LIMITATION ON ADJUSTMENT.—

(A) IN GENERAL.—The adjustment under paragraph (1) may not result, with respect to BasiCare health benefit plans offered by car-

riers to groups and individuals in the same community, in a premium rate for the most expensive age group exceeding the average community rate by more than the applicable percent (as defined in subparagraph (B)).

(B) APPLICABLE PERCENT DEFINED.—In subparagraph (A), the term ''applicable percent'' means—

(i) for the first effective year, 50 percent,

(ii) for the second effective year, 40 percent,

(iii) for the third effective year, 30 percent, and

(iv) for any subsequent year, 20 percent.

(l) APPLICATION OF STANDARDS TO REINSURANCE POLICIES.—The requirements of this section shall apply to all reinsurance policies sold by an entity to a carrier offering BasiCare health benefit plans through self-insured employment-related health benefit plans.

(m) APPLICATION OF BASICARE BASE PREMIUM RATE.—For the first year of standardization of the BasiCare health benefit plan under this Act, premiums charged for BasiCare health benefit plans may not exceed

the BasiCare base premium rate, as provided in section 216.

(n) APPLICATION OF ALLOWED RATE OF INCREASE.—

(1) IN GENERAL.—A carrier may not charge premiums with respect to BasiCare health benefit plans in any calendar year which exceed the greater of—

(A) the previous year's rate plus the annual allowable percentage rate of increase for the year as provided in section 213; or

(B) the applicable base premium rate, as provided in section 216, plus amounts corresponding to the cumulative total of annual allowable percentage rates of increase up to the current year.

(2) EXCEPTION.—Notwithstanding paragraph (1)(B), in any single calendar year a carrier may not increase its premium with respect to a BasiCare health benefit plan by an amount exceeding 120 percent of the national annual allowable percentage rate of increase for that year, as provided in section 213.

(o) RISK-ADJUSTMENT STRUCTURE.—In preparing its recommendation to Congress under section 212 of this Act, the Commission shall provide guidelines for a risk-

adjustment structure under which all BasiCare health benefit plans in a State are assigned a numerical risk index based on risk-adjustment factors developed by the Commission and based on such index low-risk carriers are required to pay an assessment and high-risk carriers are designated to receive a subsidy in order to balance the risk of doing business in such State. The Commission shall administer such a risk-adjustment structure in any State in which the applicable regulatory authority fails to do so.

SEC. 216. BASICARE BASE PREMIUM RATE.

(a) CRITERIA.—In developing the legislative proposal described in section 212(a)(3), the BasiCare base premium rate established and recommended by the Commission shall be based on the anticipated average cost of providing the BasiCare benefits package to an average group of beneficiaries (as determined by the Commission in consultation with the Board).

(b) LIMITED VARIATION ALLOWED.—In establishing the BasiCare base premium rate, the Commission may propose limited variations in such rate to accommodate geographic variables, or other variables as described in paragraphs (1) and (2).

(1) GEOGRAPHIC VARIABLES.—In order to accommodate differences in costs in delivering health care in different geographical areas, the Commission

may provide for limited geographical variations in the BasiCare base premium rate to the extent such variations are—

(A) based on statistically verifiable differences in the cost of providing the BasiCare benefits package, and

(B) not provided for geographic areas smaller than areas that encompass at least—

(i) one or more adjacent metropolitan statistical areas (as defined by the Commission, in consultation with the Bureau of the Census); or

(ii) the total remaining area within a State not otherwise included in a geographic area described under clause (i).

(2) OTHER VARIABLES.—If the Commission has provided for variation in the BasiCare benefits package under paragraph (2) of section 214(b), the Commission may provide for variations in the BasiCare base premium rate to reflect such variations in the benefit package, to the extent such variations meet the criteria for allowing variations under paragraph (2) of such section. Also, to the extent that adjustments to community rating of BasiCare health benefit plans are permitted under section 215(k), the

Commission may provide for corresponding variation in the BasiCare base premium rate to reflect such permitted adjustments. If variations are provided for in the BasiCare base premium rate, such variations shall be expressed in terms of percentage variation from a single standard national rate.

SEC. 217. EMPLOYER RESPONSIBILITIES UNDER BASICARE.

In developing the legislative proposal described in section 212(a)(4), the Commission shall require the following:

(1) NO DISCRIMINATION BASED ON HEALTH STATUS FOR CERTAIN SERVICES.—An employment-related BasiCare health benefit plan may not deny, limit, or condition coverage based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

(2) TREATMENT OF PREEXISTING CONDITION EXCLUSIONS.—An employment-related BasiCare health benefit plan may not exclude or otherwise discourage coverage with respect to services related to treatment of a preexisting condition.

(3) TREATMENT OF WAITING PERIODS.—An employment-related BasiCare health benefit plan may not impose waiting periods of any length.

(4) NO DISCRIMINATION BASED ON INCOME LEVEL.—An employment-related BasiCare health benefit plan shall apply equally to employees of all income levels.

(5) EQUAL CONTRIBUTION LEVELS.—The total amount of an employer's contribution to the cost of coverage under an employment-related BasiCare health benefit plan for employees with incomes less than 200 percent of the income official poverty line (as described in section 232(g)(1)) shall equal or exceed such total amount for employees with incomes greater than 200 percent of such income official poverty line.

SEC. 218. INDIVIDUAL RESPONSIBILITIES UNDER BASICARE.

Subject to the provisions of subsections (h) and (i) of section 213, in developing the legislative proposal described in section 212(a)(5), the Commission shall require that to be eligible for benefits under a Federal program, an individual seeking benefits under such program shall certify to the administrator of such program that such individual and the dependents of such individual possess BasiCare health insurance coverage that meets the applicable minimum standards under this title. Except as may be provided by the Commission under section 214(c)(1),

this section shall not apply to persons eligible for enrollment in—

(1) the medicare program under title XVIII of the Social Security Act,

(2) the veterans health care program under chapter 17 of title 38, United States Code,

(3) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code,

(4) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), and

(5) the Federal employees program under chapter 89 of title 5, United States Code.

SEC. 219. SELF-INSURED PLAN REQUIREMENTS.

(a) IN GENERAL.—In developing the legislative proposal described in section 212(a)(6), the Commission shall require that in order to obtain certification as a BasiCare health benefit plan as provided in section 213(m), a self-insured health benefit plan must demonstrate to the satisfaction of the Commission that—

(1) the benefits and conditions of such plan (including copayments and deductibles) are substantially equivalent to those of a BasiCare health benefit plan as provided under this Act;

(2) the self-insuring entity is adhering to non-discrimination standards substantially equivalent to those provided for carriers in section 215 (insurance reform requirements) and described in subsection (b);

(3) the average per capita cost of providing BasiCare equivalent benefits to enrollees in the self-insured plan differs no more than 10 percent (either above or below) from the average per capita cost of providing BasiCare benefits package to non-self-insured beneficiaries in the community (or communities) in which the self-insured group is located (without taking into account any reductions in costs due to health promotion activities of the employer); and

(4) the self-insuring entity possesses adequate financial reserves, as determined by the Commission, to assure the immediate and long-term solvency of the entity and the benefits of individuals receiving coverage through such entity.

(b) STANDARDS DESCRIBED.—Standards described in this subsection shall include (but are not limited to) the following:

(1) NO DISCRIMINATION BASED ON HEALTH STATUS.—No self-insured BasiCare health benefit

plan may deny, limit, or condition the coverage under (or benefits of) the plan with respect to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual or group.

(2) TREATMENT OF PREEXISTING CONDITIONS.—No self-insured BasiCare health benefit plan may exclude or otherwise discourage coverage with respect to services related to treatment of a preexisting condition.

(3) WAITING PERIODS.—No self-insured BasiCare health benefit plan may impose waiting periods of any length.

SEC. 220. PROVIDER RESPONSIBILITIES UNDER BASICARE.

In developing the legislative proposal described in section 212(a)(7), the Commission shall require as a condition of participation in the BasiCare health benefit plan by any health care provider the acceptance by such provider of any payment by BasiCare as full payment for the service performed.

SEC. 221. DEVELOPMENT OF STANDARDS FOR MANAGED CARE PLANS.

(a) IN GENERAL.—In preparing the legislative proposal described in section 212(a)(8), the Commission, taking into account recommendations of the Managed Care

Advisory Committee (as described in subsection (b)), shall develop recommended standards that carriers offering managed care plans should meet with respect to the benefits, coverage, and delivery systems provided under such plans. Such standards shall encompass the standards by which managed care entities operate.

(b) MANAGED CARE ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—There shall be established a Managed Care Advisory Committee (hereinafter referred to as the ''Committee'').

(2) MEMBERSHIP.—The Committee shall be composed of 5 members appointed by the Chairperson of the Commission, each member representing 1 of the following areas:

(A) Health care professionals.

(B) Managed care industry.

(C) Academia (with specific expertise in managed care plans).

(D) Business management.

(E) Organized labor.

(3) COMPENSATION.—

(A) IN GENERAL.—Members of the Committee shall serve without compensation.

(B) EXPENSES, ETC., REIMBURSED.—While away from their homes or regular places

of business on the business of the Committee, the members may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons employed intermittently in Government service.

(C) APPLICATION OF ACT.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply with respect to the Committee.

(D) SUPPORT.—The Commission shall supply such necessary office facilities, office supplies, support services, and related expenses as necessary to carry out the functions of the Committee.

SEC. 222. PREEMPTION OF PROVISIONS RELATING TO MANAGED CARE.

In developing the legislative proposal described in section 212(a)(8), the Commission shall provide that in the case of a managed care plan meeting the recommended standards under section 221 that is offered by a carrier, the following provisions of law are preempted and may not be enforced against the managed care plan with respect to a carrier offering such plan:

(1) RESTRICTIONS ON REIMBURSEMENT RATES OR SELECTIVE CONTRACTING.—Any law that restricts the ability of the carrier to negotiate reimbursement rates with health care providers or to contract selectively with one provider or a limited number of providers.

(2) RESTRICTIONS ON DIFFERENTIAL FINANCIAL INCENTIVES.—Any law that limits the financial incentives that the managed care plan may require a beneficiary to pay when a non-plan provider is used on a non-emergency basis.

(3) RESTRICTIONS ON UTILIZATION REVIEW METHODS.—

(A) IN GENERAL.—Any law that—

(i) prohibits utilization review of any or all treatments and conditions;

(ii) requires that such review be made by a resident of the State in which the treatment is to be offered or by an individual licensed in such State, or by a physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered;

(iii) requires the use of specified standards of health care practice in such review or requires the disclosure of the specific criteria used in such review;

(iv) requires payments to providers for the expenses of responding to utilization review requests; or

(v) imposes liability for delays in performing such review.

(B) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as prohibiting a State from requiring that utilization review be conducted by a licensed health care professional, or requiring that any appeal from such a review be made by a licensed physician or by a licensed physician in any particular specialty or with any board certified specialty of the same medical specialty as the provider whose services are being rendered.

(4) RESTRICTIONS ON BENEFITS.—Any law that mandates benefits under the managed care plan that are greater than the benefits recommended under the standards developed under section 221.

(5) ERISA.—Any provision of the Employee Retirement Income Security Act to the extent inconsistent with the managed care plan.

Subtitle C—Low-Income Assistance

SEC. 231. TRANSFER FROM MEDICAID TO BASICARE.

(a) IN GENERAL.—In developing the legislative proposal described in section 212(a)(9)(A), the Commission shall provide for the orderly termination of medicaid program coverage under title XIX of the Social Security Act, to the extent that such coverage duplicates the BasiCare benefits package.

(b) TRANSFER OF COVERED INDIVIDUALS FROM MEDICAID TO BASICARE.—Such proposal shall require each State—

(1) to notify medicaid beneficiaries of the impending transfer of coverage of such beneficiaries to the BasiCare program not later than 1 year prior to the date of transfer from medicaid to the BasiCare program; and

(2) to provide such information and assistance as may be necessary to assure the enrollment of all medicaid beneficiaries in BasiCare health benefit plans upon the establishment of such plans.

(c) PROVISIONAL TREATMENT OF MEDICAID BENEFITS NOT COVERED BY BASICARE.—Such proposal shall require—

(1) that for a period of 5 years following the termination of medicaid benefits that duplicate the BasiCare benefits package, the medicaid program shall continue to operate with respect to the provision of any existing benefits which are not covered under the BasiCare benefits package; and

(2) Federal rules and regulations regarding the medicaid program shall remain in effect during a transition period subject to such adjustments deemed necessary by the Commission to carry out the medicaid-to-BasiCare transfer described in this section.

(d) FINAL DISPOSITION OF MEDICAID BENEFITS.—Upon expiration of the 5-year transition period described in subsection (c)(1), Federal funding for any existing medicaid benefits which are not covered under the BasiCare benefits package shall be discontinued, unless Congress has approved a plan for alternate disposition of such benefits, as provided in section 213.

SEC. 232. LOW-INCOME ASSISTANCE WITH COSTS OF BASICARE INSURANCE.

(a) IN GENERAL.—In developing the legislative proposal described in section 212(a)(9)(B), the Commission shall provide for a BasiCare public assistance program (hereafter in this section referred to as ''BasiCare Assist'') which, at a minimum, meets the requirements of the following subsections of this section.

(b) ASSISTANCE FOR UNDER-POVERTY FAMILIES.—In the case of an individual who is a member of an under-poverty family, BasiCare Assist shall provide for payment of—

(1) premiums charged the individual for coverage under a BasiCare health benefit plan in which the individual is enrolled; and

(2) deductibles and other cost-sharing imposed on the individual under such plan, other than a per service copayment, not to exceed $5 per service, as determined by the Commission.

(c) ASSISTANCE FOR NEAR-POVERTY FAMILIES.—

(1) IN GENERAL.—In the case of an individual who is a member of a near-poverty family, BasiCare Assist shall provide for payment of the applicable percentage of any premiums, deductibles, and other cost-sharing charged the individual for coverage

under a BasiCare health benefit plan in which the individual is enrolled.

(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the term ''applicable percentage'' means 100 percent reduced (but not below zero percent) by 10 percentage points for each 10 percentage point bracket (or portion thereof) such family's income equals or exceeds 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(d) ADJUSTMENT OF ASSISTANCE.—The Commission shall provide for appropriate adjustments to any assistance under this section to reflect partial family coverage under an employment-related BasiCare health benefit plan.

(e) APPLICATION FOR ASSISTANCE.—BasiCare Assist shall use a standard Federal application which shall be as simple in form as possible and understandable to the average individual, and shall require attachment of such documentation as deemed necessary by the Commission in order to ensure eligibility for assistance. Such application shall be available to any individual or family, may be filed

at any time, and as provided in subsection (f), may initiate coverage under a BasiCare health benefit plan. The Commission shall use, as deemed practicable by the Commission, any existing forms employed for Federal income tax filings as an application for BasiCare Assist.

(f) ENROLLMENT AT POINT OF APPLICATION.—To the extent practicable, the Commission shall provide for the option of enrollment in a BasiCare health benefit plan as part of the application and approval process for assistance under this section. In providing for such an option, the Commission may require carriers of BasiCare health benefit plans to provide such information and assistance as may be necessary.

(g) PAYMENT OF PREMIUMS, DEDUCTIBLES, AND OTHER COST-SHARING.—BasiCare Assist shall provide to an individual a voucher for the applicable percentage of BasiCare premiums, deductibles, and other cost-sharing for which such individual qualifies under subsection (b) or (c). Such voucher shall be remitted by the individual to the carrier of BasiCare health benefit plans (or, in the case of an employment-related BasiCare health benefit plan, to the individual's employer) for payment by BasiCare Assist. Such carrier shall make proper adjustments in billing statements to reflect such individual's re-

maining premium obligations, deductibles, and other cost-sharing (if any).

(h) DOCUMENTATION OF ELIGIBILITY.—

(1) REQUIREMENT FOR FILING OF INCOME STATEMENT.—In the case of a family which is receiving assistance under BasiCare Assist for any month in a year, a member of the family shall file a statement with the Commission, at such intervals during such year as the Commission deems necessary, and by not later than April 15 of the following year. Such a statement shall provide information necessary to determine the family income and the number of family members in the family during the year.

(2) RECONCILIATION OF ASSISTANCE BASED ON ACTUAL INCOME.—Based on and using the income reported in the statement filed under paragraph (1) with respect to a family, the Commission shall compute the amount of assistance that should have been provided under BasiCare Assist with respect to the family in the year involved and make proper adjustments in future assistance. If the amount of such assistance computed is—

(A) greater than the amount of assistance provided, the Commission shall provide for pay-

ment to the family involved of an amount equal to the amount of the deficit, or

(B) less than the amount of assistance provided, the Commission shall require the family to pay to the Federal Government (to the credit of BasiCare Assist) an amount equal to the amount of the excess payment.

(3) DISQUALIFICATION FOR FAILURE TO FILE.—In the case of any family that is required to file an information statement under paragraph (1) for a year and that fails to file such a statement by the deadline specified by the Commission, no member of the family shall be eligible for assistance under this section after such deadline. The Commission shall waive the application of this paragraph if the family establishes, to the satisfaction of the Commission, good cause for the failure to file the statement on a timely basis.

(4) PENALTIES FOR FALSE INFORMATION.—

(A) INTEREST FOR UNDERSTATEMENTS.—Each individual who knowingly understates income reported in an application for assistance under BasiCare Assist or any statement described in paragraph (1), or otherwise makes a material misrepresentation of information in

such an application or statement shall be liable to the Federal Government for excess payments made based on such understatement or misrepresentation, and for interest on such excess payments at a rate specified by the Commission.

(B) PENALTIES FOR MISREPRESENTATION.—Each individual who knowingly misrepresents material information in an application for assistance under BasiCare Assist or any statement described in paragraph (1) shall be liable to the Federal Government for $1,000 or, if greater, 3 times the excess payments made based on such misrepresentation.

(5) NOTICE OF REQUIREMENT.—The Commission shall provide for written notice, in March of each year, of the requirement of paragraph (1) to each family which received assistance under BasiCare Assist in any month during the preceding year and to which such requirement applies.

(6) TRANSMITTAL OF INFORMATION.—The Secretary of the Treasury shall transmit annually to the Commission such information relating to the total income of individuals and families for the taxable year ending in the previous year as may be nec-

essary to verify the reconciliation of assistance under BasiCare Assist.

(i) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) UNDER-POVERTY FAMILY.—The term ''under-poverty family'' means a family whose income is less than 100 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(2) NEAR-POVERTY FAMILY.—The term ''near-poverty family'' means a family whose income equals or exceeds 100 percent of the income official poverty line (as described in paragraph (1)), but is less than 200 percent of such income official poverty line.

(3) DETERMINATIONS OF INCOME.—

(A) IN GENERAL.—The term ''income'' means—

(i) adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986), determined without the application of paragraphs (6) and (7) of such

section and without the application of section 162(l) of such Code, plus

(ii) the amount of social security benefits (described in section 86(d) of such Code) which is not includable in gross income under section 86 of such Code.

(B) FAMILY INCOME.—The term ''family income'' means, with respect to an individual, the sum of the income for the individual and all the other family members.

(C) FAMILY SIZE.—The family size to be applied under this section, with respect to family income, is the number of individuals included in the family for purposes of coverage of a BasiCare health benefit plan.

(D) TIMING OF DETERMINATION.—Income shall be determined in accordance with one of the following methods, at the option of the applicant, for coverage under this section:

(i) Multiplying by a factor of 4 the family income of the applicant for the 3-month period immediately preceding the month in which the application for assistance under BasiCare is made.

(ii) Determining the family income of the applicant for the month in which the application for such assistance is made.

(j) EFFECTIVE DATE.—The provisions of this section shall take effect on the effective date of the legislation described in section 212(a) or 213(a) of this Act.

Subtitle D—Congressional Consideration of Commission Recommendation

SEC. 241. RULES GOVERNING CONGRESSIONAL CONSIDERATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of approval resolutions described in subsection (b), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time,

in the same manner and to the same extent as in the case of any other rule of that House.

(b) TERMS OF THE RESOLUTION.—For purposes of section 212(b), the term ''approval resolution'' means only a joint resolution of the two Houses of the Congress, providing in—

(1) the matter after the resolving clause of which is as follows: ''That the Congress approves the recommendations of the Commission on National Health Care Access and Reform as submitted by the Commission on _____'', the blank space being filled in with the appropriate date; and

(2) the title of which is as follows: ''Joint Resolution approving the recommendation of the Commission on National Health Care Access and Reform''.

(c) INTRODUCTION AND REFERRAL.—On the day on which the recommendation of the Commission is transmitted to the House of Representatives and the Senate, an approval resolution with respect to such recommendation shall be introduced (by request) in the House of Representatives by the Majority Leader of the House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader of the

House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader and Minority Leader of the House; and shall be introduced (by request) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate. If either House is not in session on the day on which such recommendation is transmitted, the approval resolution with respect to such recommendation shall be introduced in the House, as provided in the preceding sentence, on the first day thereafter on which the House is in session. The approval resolution introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(d) AMENDMENTS PROHIBITED.—No amendment to an approval resolution shall be in order in either the House of Representatives or the Senate; and no motion to suspend the application of this subsection shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this subsection by unanimous consent.

(e) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(1) IN GENERAL.—Except as provided in paragraph (2), if the committee or committees of either House to which an approval resolution has been referred have not reported it at the close of the 45th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the approval resolution and it shall be placed on the appropriation calendar. A vote on final passage of the approval resolution shall be taken in each House on or before the close of the 45th day after the approval resolution is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the approval resolution. If prior to the passage by one House of an approval resolution of that House, that House receives the same approval resolution from the other House then—

(A) the procedure in that House shall be the same as if no approval resolution had been received from the other House; but

(B) the vote on final passage shall be on the approval resolution of the other House.

(2) COMPUTATION OF DAYS.—For purposes of paragraph (1), in computing a number of days in ei-

ther House, there shall be excluded any day on which the House is not in session.

(f) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(1) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an approval resolution shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(2) DEBATE.—Debate in the House of Representatives on an approval resolution shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the bill or resolution. A motion further to limit debate shall not be debatable. It shall not be in order to move to recommit an approval resolution or to move to reconsider the vote by which an approval resolution is agreed to or disagreed to.

(3) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an approval resolution, and motions to proceed to the consideration of other business, shall be decided without debate.

(4) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an approval resolution shall be decided without debate.

(5) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this subsection, consideration of an approval resolution shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(g) FLOOR CONSIDERATION IN THE SENATE.—

(1) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of an approval resolution shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(2) GENERAL DEBATE.—Debate in the Senate on an approval resolution, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the Majority Leader and the Minority Leader or their designees.

(3) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an approval resolution shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the approval resolution, except that in the event the manager of the approval resolution is in favor of any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of an approval resolution, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(4) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit an approval resolution is not in order.

(h) POINT OF ORDER REQUIRING SUPERMAJORITY FOR MODIFICATIONS TO RECOMMENDATION ONCE APPROVED.—

(1) IN GENERAL.—It shall not be in order in the House of Representatives or the Senate to consider any amendment to the provisions of the BasiCare Health Access and Reform Act except as provided in paragraph (2).

(2) WAIVER.—The point of order described in paragraph (1) may be waived or suspended in the House of Representatives or the Senate only, by the affirmative vote of three-fifths of the Members duly chosen and sworn.

Subtitle E—Enforcement Provisions

SEC. 251. ENFORCEMENT PROVISIONS FOR CARRIERS, PROVIDERS, AND EMPLOYERS.

(a) IN GENERAL.—Chapter 47 of the Internal Revenue Code of 1986 (relating to excise taxes on qualified pension, etc. plans) is amended by striking section 5000 and section 5000A (as added by section 106) and inserting the following new sections:

"SEC. 5000. FAILURE OF CARRIERS WITH RESPECT TO BASICARE INSURANCE.

''(a) GENERAL RULE.—In the case of any carrier offering any health benefit plan, there is hereby imposed a tax on such carrier if such plan fails to qualify as a Basicare health benefit plan.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 50 percent of the gross premiums received during such taxable

year with respect to all health benefit plans issued by the carrier on whom such tax is imposed.

''(2) GROSS PREMIUMS.—For purposes of paragraph (1), gross premiums shall include any consideration received with respect to any health benefit contract.

''(3) CONTROLLED GROUPS.—For purposes of paragraph (1)—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 carrier. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or businesses (whether or not incor-

porated) which are under common control shall be treated as 1 carrier. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the carrier on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

''(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the carriers on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(d) COMPLIANCE DETERMINATION.—

''(1) IN GENERAL.—The Commission on National Health Care Access and Reform (hereafter in this subsection referred to as the 'Commission' shall determine whether any health benefit plan qualifies as a BasiCare health benefit plan.

''(2) STATE AGREEMENTS.—

''(A) IN GENERAL.—The Commission may, in its discretion, enter into an agreement with any State to provide for the State to make the initial determination described in paragraph (1).

''(B) STANDARDS.—An agreement may be entered into under subparagraph (A) only if—

''(i) the chief executive officer of the State requests such agreement be entered into,

''(ii) the Commission determines that the State agreement will apply to substan-

tially all health benefit plans issued in such State, and

''(iii) the Commission determines that the application of the State agreement will carry out the purposes of this section.

''(3) TERMINATION.—The Commission shall terminate any agreement if the Commission determines that the application of the State agreement ceases to carry out the purposes of this section.

''(e) DEFINITIONS.—For purposes of this section the terms 'health benefit plan', 'BasiCare health benefit plan', and 'carrier' shall have the same meanings given such terms under section 271 of the BasiCare Health Access and Cost Control Act.

"SEC. 5000A. FAILURE OF PROVIDERS WITH RESPECT TO BASICARE INSURANCE.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any person who provides any service under a BasiCare health benefit plan to comply with the requirements of section 220 of the BasiCare Health Access and Cost Control Act.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of tax imposed by subsection (a) by reason of 1 or more failures during a taxable year shall be equal to 50 percent

of the gross income received during such taxable year with respect to all services provided by the person on whom such tax is imposed.

''(2) CONTROLLED GROUPS.—For purposes of paragraph (1)—

''(A) CONTROLLED GROUP OF CORPORATIONS.—All corporations which are members of the same controlled group of corporations shall be treated as 1 person. For purposes of the preceding sentence, the term 'controlled group of corporations' has the meaning given to such term by section 1563(a), except that—

''(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears in section 1563(a)(1), and

''(ii) the determination shall be made without regard to subsections (a)(4) and (e)(3)(C) of section 1563.

''(B) PARTNERSHIPS, PROPRIETORSHIPS, ETC., WHICH ARE UNDER COMMON CONTROL.—Under regulations prescribed by the Secretary, all trades or business (whether or not incorporated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based

on principles similar to the principles which apply in the case of subparagraph (A).

''(c) LIMITATION ON TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

''(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the 1st date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all

of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(d) COMPLIANCE DETERMINATION.—

''(1) IN GENERAL.—The Commission on National Health Care Access and Reform (hereafter in this subsection referred to as the 'Commission' shall determine compliance with the requirements of section 220 of the BasiCare Health Access and Cost Control Act.

''(2) STATE AGREEMENTS.—

''(A) IN GENERAL.—The Commission may, in its discretion, enter into an agreement with any State to provide for the State to make the initial determination described in paragraph (1).

''(B) STANDARDS.—An agreement may be entered into under subparagraph (A) only if—

''(i) the chief executive officer of the State requests such agreement be entered into,

''(ii) the Commission determines that the State agreement will apply to substantially all providers of services under health benefit plans issued in such State, and

''(iii) the Commission determines that the application of the State agreement will carry out the purposes of this section.

''(3) TERMINATION.—The Commission shall terminate any agreement if the Commission determines that the application of the State agreement ceases to carry out the purposes of this section.

''(e) DEFINITIONS.—For purposes of this section the terms 'health benefit plan' and 'BasiCare health benefit plan' shall have the same meanings given such terms under section 271 of the BasiCare Health Access and Cost Control Act.

"SEC. 5000B. FAILURE OF EMPLOYERS WITH RESPECT TO BASICARE INSURANCE.

''(a) GENERAL RULE.—There is hereby imposed a tax on the failure of any person to comply with the requirements of sections 217 and 219 of the BasiCare Health Access and Cost Control Act with respect to any full-time employee of the person.

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure with respect to a full-time employee shall be $50 for each day in the noncompliance period with respect to such failure.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

''(A) beginning on the date such failure first occurs, and

''(B) ending on the date such failure is corrected.

''(3) CORRECTION.—A failure of a person to comply with the requirements of sections 217 and 219 of the BasiCare Health Access and Cost Control Act with respect to any full-time employee of the person shall be treated as corrected if—

''(A) such failure is retroactively undone to the extent possible, and

''(B) the employee is placed in a financial position which is as good as such employee would have been in had such failure not occurred.

For purposes of applying subparagraph (B), the employee shall be treated as if the employee had elected the most favorable coverage in light of the expenses incurred since the failure first occurred.

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILI-

GENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that none of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the first date any of the persons referred to in subsection (d) knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(d) LIABILITY FOR TAX.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, the following shall be liable for the tax imposed by subsection (a) on a failure:

''(A) In the case of a BasiCare health benefit plan other than a multiemployer plan, the employer.

''(B) In the case of a multiemployer plan, the plan.

''(C) Each person who is responsible (other than in a capacity as an employee) for administering or providing benefits under the BasiCare health benefit plan and whose act or failure to act caused (in whole or in part) the failure.

''(2) SPECIAL RULES FOR PERSONS DESCRIBED IN PARAGRAPH (1)(C).—A person described in subparagraph (C) (and not in subparagraphs (A) and (B)) of paragraph (1) shall be liable for the tax imposed by subsection (a) on any failure only if such person assumed (under a legally enforceable written agreement) responsibility for the performance of the act to which the failure relates.

''(e) DEFINITIONS.—For purposes of this section, the terms 'BasiCare health benefit plan' and 'full-time employee' shall have the same meanings given such terms

under section 271 of the BasiCare Health Access and Cost Control Act.''.

(b) CLERICAL AMENDMENTS.—The table of sections for such chapter 47 is amended by adding at the end thereof the following new items:

''Sec. 5000. Failure of carriers with respect to BasiCare insurance.
''Sec. 5000A. Failure of providers with respect to BasiCare insurance.
''Sec. 5000B. Failure of employers with respect to BasiCare insurance.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the effective date of the legislation described in section 212(a) or 213(a) of this Act.

SEC. 252. ENFORCEMENT PROVISION FOR INDIVIDUALS.

(a) IN GENERAL.—Subsection (d) of section 151 of the Internal Revenue Code of 1986 (relating to allowance of deductions for personal exemptions) is amended by adding at the end thereof the following new paragraph:

''(5) EXEMPTION AMOUNT DISALLOWED FOR UNINSURED INDIVIDUALS.—The exemption amount for any individual for such individual's taxable year shall be zero, unless the policy number of the BasiCare health benefit plan (as defined in section 271 of the BasiCare Health Access and Cost Control Act) for such individual is included in the return

claiming such exemption amount for such individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the effective date of the legislation described in section 212(a) or 213(a) of this Act.

Subtitle F—Financial Provisions

SEC. 261. BASICARE TRUST FUND.

(a) TRUST FUND ESTABLISHED.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the BasiCare Trust Fund (hereafter in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, appropriated to, or credited to such Trust Fund as provided in this section.

(b) TRANSFER OF AMOUNTS EQUIVALENT TO CERTAIN TAXES.—

(1) IN GENERAL.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of—

(A) 1 percent of the wages (as defined in section 3121 of the Internal Revenue Code of 1986) paid on or after the first day of the calendar year following the date of the enactment

of this Act, and reported to the Secretary of the Treasury or the Secretary's delegate pursuant to subtitle F of the Internal Revenue Code of 1986, and

(B) 1 percent of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1986) reported to the Secretary of the Treasury or the Secretary's delegate on tax returns under subtitle F of the Internal Revenue Code of 1986 for any taxable year beginning on or after the first day of the calendar year following the date of the enactment of this Act.

(2) PENALTIES.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the taxes imposed under sections 5000, 5000A, and 5000B of the Internal Revenue Code of 1986.

(3) ADDITIONAL REVENUES.—There are hereby appropriated to the Trust Fund amounts equivalent to the additional revenues received in the Treasury as the result of the amendments made by section 262 of this Act.

(4) TRANSFERS BASED ON ESTIMATES.—The amounts appropriated by paragraphs (1), (2), and

(3) shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in such subparagraphs, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such subparagraphs.

(c) TRANSFER OF ADDITIONAL FUNDS.—

(1) STATE SHARE OF MEDICAID FUNDING.—

(A) IN GENERAL.—On a fiscal year basis, each State shall remit to the Trust Fund the State's medicaid share for that fiscal year.

(B) STATE'S MEDICAID SHARE.—

(i) IN GENERAL.—With respect to any fiscal year beginning after the applicable effective date of the legislation described in section 212(a) or 213(a) of this Act, a State's medicaid share shall equal the amount such State expended under title XIX of the Social Security Act for the fiscal year preceding such applicable effective date for benefits equal to the BasiCare

benefits package, as determined by the Commission, in consultation with the Secretary of Health and Human Services and State medicaid authorities. Such amount shall be adjusted each fiscal year by the increase in the Consumer Price Index (as determined by the Department of Labor) for the previous fiscal year.

(ii) AMOUNT UPON COMPLETE ASSIMILATION OF MEDICAID.—The amount otherwise determined under clause (i) for the fiscal year beginning after the applicable effective date of the legislation described in section 213(h) of this Act shall be increased by the amount such State expended under title XIX of the Social Security Act for the fiscal year preceding such applicable effective date.

(C) COMPLIANCE.—The requirements of this paragraph shall be subject to the provisions of section 1904 of the Social Security Act.

(2) FEDERAL SHARE OF MEDICAID FUNDING.—There are hereby appropriated for each fiscal year described in paragraph (1) the comparable Federal share expended under title XIX of the Social Secu-

rity Act for such fiscal year, as adjusted under paragraph (1)(B)(i).

(3) MEDICARE FUNDS.—All amounts, not otherwise obligated, that remain in the Federal Hospital Insurance Trust Fund and the Federal Supplemental Medical Insurance Trust Fund on the applicable effective date of the legislation described in section 213(i) of this Act shall be transferred to the Trust Fund.

(4) ADDITIONAL FEDERAL FUNDS.—There are hereby appropriated to the Trust Fund for each fiscal year beginning after the applicable effective date of the legislation described in 213(j) of this Act, amounts equal to the amounts appropriated with respect to—

(A) the veterans health care program under chapter 17 of title 38, United States Code,

(B) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1073(4) of title 10, United States Code,

(C) the Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), and

(D) the Federal employees program under chapter 89 of title 5, United States Code,

as in effect on the day before such applicable effective date, as adjusted under paragraph (1)(B)(i).

(5) APPROPRIATION OF ADDITIONAL SUMS.—There are hereby authorized to be appropriated to the Trust Fund such additional sums as may be required to make expenditures referred to in subsection (e).

(e) EXPENDITURES.—

(1) LOW-INCOME ASSISTANCE.—There are hereby authorized and appropriated such sums as are necessary in each fiscal year for the expenses of the program described in section 241.

(2) ADMINISTRATIVE EXPENSES.—There are hereby appropriated such sums as are authorized under section 203 for the administrative and other expenses of the Commission for each fiscal year.

(3) TITLE I EXPENDITURES.—Amounts in the Trust Fund shall be available, as provided in appropriation Acts, for authorized expenditures described in—

(A) sections 330A(h) and 330B(h) of the Public Health Service Act, as added by sections 111 and 112 of this Act, and

(B) sections 150 and 151(g) of this Act.

(e) INVESTMENT OF TRUST FUND.—

(1) IN GENERAL.—It shall be the duty of the Secretary of the Treasury to invest such portion of the Trust Fund as is not, in the Secretary's judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose, such obligations may be acquired—

(A) on original issue at the issue price, or

(B) by purchase of outstanding obligations at the market price.

The purposes for which obligations of the United States may be issued under chapter 31 of title 31, of the United States Code, are hereby extended to authorize the issuance at par of special obligations exclusively to the Trust Fund. Such special obligations shall bear interest at a rate equal to the average rate of interest, computed as to the end of the calendar month next preceding the date of such issue, borne by all marketable interest-bearing obligations of the United States then forming a part of the Public Debt; except that where such average rate

is not a multiple of one-eighth of 1 percent, the rate of interest of such special obligations shall be the multiple of one-eighth of 1 percent next lower than such average rate. Such special obligations shall be issued only if the Secretary of the Treasury determines that the purchase of other interest-bearing obligations of the United States, or of obligations guaranteed as to both principal and interest by the United States on original issue or at the market price, is not in the public interest.

(2) SALE OF OBLIGATION.—Any obligation acquired by the Trust Fund (except special obligations issued exclusively to the Trust Fund) may be sold by the Secretary of the Treasury at the market price, and such special obligations may be redeemed at par plus accrued interest.

(3) CREDITS TO TRUST FUND.—The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) REPORT TO CONGRESS.—It shall be the duty of the Secretary of the Treasury to hold the Trust Fund, and (after consultation with the Commission) to report to the Congress each year on the financial condition and the results of the operations of the Trust Fund during the

preceding fiscal year and on its expected condition and operations during the next fiscal year. Such report shall be printed as both a House and Senate document of the session of the Congress to which the report is made.

(g) CONFORMING AMENDMENT.—Paragraph (4) of section 201(a) of the Social Security Act (42 U.S.C. 401(a)) is amended by inserting ''and section 261(1)(1) of the BasiCare Health Access and Cost Control Act'' before the end period.

SEC. 262. TAX TREATMENT OF COSTS OF BASICARE INSURANCE.

(a) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED HEALTH INSURANCE.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by striking ''an accident or health plan'' and inserting ''a BasiCare health benefit plan (as defined in section 271(1) of the BasiCare Health Access and Cost Control Act)''.

(b) BUSINESS EXPENSE DEDUCTION FOR HEALTH INSURANCE.—Section 162 of the Internal Revenue Code of 1986 (relating to trade or business expenses) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

''(m) GROUP HEALTH PLANS.—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless the plan qualifies as a BasiCare health benefit plan (as defined in section 271(1) of the BasiCare Health Access and Cost Control Act).''.

(c) RULES RELATING TO DEDUCTIONS FOR INDIVIDUALS.—

(1) DEDUCTION LIMITED TO BASICARE.—Subparagraph (C) of section 213(d)(1) of such Code (defining medical care) is amended by striking ''for insurance'' and inserting ''for a BasiCare health benefit plan (as defined in section 271(1) of the BasiCare Health Access and Cost Control Act).''.

(2) FULL DEDUCTION ALLOWED.—Section 213 of such Code (relating to medical, dental, etc., expenses) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULES FOR BASICARE PREMIUM EXPENSES.—

''(1) IN GENERAL.—The deduction under subsection (a) shall be determined without regard to the limitation based on adjusted gross income with respect to amounts paid for premiums for coverage under a Basicare health benefit plan (as defined in

section 271(1) of the BasiCare Health Access and Cost Control Act).

''(2) LIMIT.—The amount allowed as a deduction under paragraph (1) with respect to the cost of providing coverage for any individual shall be reduced by the aggregate amount of payments to, or on behalf of, such individual by—

''(A) BasiCare Assist under section 232 of the BasiCare Health Access and Cost Control Act, and

''(B) all other entities (including any employer or governmental agency),

for coverage of such individual under a BasiCare health benefit plan (as so defined).''

(3) DEDUCTION ALLOWED AGAINST GROSS INCOME.—Section 62(a) of such Code (defining adjusted gross income) is amended by inserting after paragraph (14) the following new paragraph:

''(15) DEDUCTION FOR BASICARE PREMIUMS.—The deduction allowed under section 213(g).''

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any taxable year beginning after the applicable effective date of the legislation described in section 212(a) or 213(a) of this Act.

Subtitle G—Definitions

SEC. 271. DEFINITIONS.

For purposes of this title:

(1) BASICARE HEALTH BENEFIT PLAN.—The term ''BasiCare health benefit plan'' means a health benefit plan which—

(A) offers the BasiCare benefits package described in section 214;

(B) applies the BasiCare base premium rate described in section 216; and

(C) meets the requirements of this title.

(2) HEALTH BENEFIT PLAN AND OTHER DEFINITIONS RELATING TO HEALTH PLANS.—For purposes of this section:

(A) HEALTH BENEFIT PLAN.—

(i) IN GENERAL.—The term ''health benefit plan'' means any hospital or medical expense incurred policy or certificate, hospital or medical service plan contract, health maintenance subscriber contract, other employee welfare plan (as defined in the Employee Retirement Income Security Act of 1964), or any other health insurance arrangement, and includes an employ-

ment-related reinsurance plan (as defined in paragraph (3)).

(ii) EXCLUSIONS.—The term 'health benefit plan' does not include—

(I) accident-only, credit, dental, or disability income insurance,

(II) coverage issued as a supplement to liability insurance,

(III) worker's compensation or similar insurance, or

(IV) automobile medical-payment insurance;

that is offered by a carrier.

(B) REINSURANCE PLAN.—The term ''reinsurance plan'' means any reinsurance or similar mechanism that underwrites a portion of the risk for a health benefit plan.

(C) SELF-INSURED HEALTH BENEFIT PLAN.—The term ''self-insured health benefit plan'' means a health benefit plan in which an employment-related group assumes the underwriting risk for the plan (whether or not there is any reinsurance or similar mechanism to underwrite a portion of that risk).

(3) CARRIER; HEALTH MAINTENANCE ORGANIZATION; AND OTHER DEFINITIONS RELATING TO CARRIERS.—For purposes of this title:

(A) CARRIER.—The term ''carrier'' means any person that offers a health benefit plan, whether through insurance or otherwise, including a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a self-insurer carrier, a reinsurance carrier, and a multiple small employer welfare arrangement (a combination of small employers associated for the purpose of providing health benefit plan coverage for their employees).

(B) HEALTH MAINTENANCE ORGANIZATION.—The term ''health maintenance organization'' has the meaning given the term 'eligible organization' in section 1876(b) of the Social Security Act, as in effect on the date of enactment of this Act.

(C) REINSURANCE CARRIER.—The term ''reinsurance carrier'' means the entity assuming responsibility for underwriting under an employment-related reinsurance plan, but does

not include a carrier insofar as it directly offers a health benefit plan.

(D) SELF-INSURER CARRIER.—The term ''self-insurer carrier'' means a carrier that is not a licensed insurance company, a prepaid hospital or medical service plan, or a health maintenance organization, that offers a health benefit plan directly with respect to an employment-related group.

(4) GENERAL DEFINITIONS.—For purposes of this title:

(A) APPLICABLE REGULATORY AUTHORITY.—The term ''applicable regulatory authority'' means, with respect to a health benefit plan offered in a State, the State commissioner or superintendent of insurance or other State authority responsible for regulation of health insurance.

(B) COMMUNITY.—The term ''community'' means a geographic area that encompasses at least—

(i) one or more adjacent metropolitan statistical areas (as defined by the Commission, in consultation with the Bureau of the Census); or

(ii) the total remaining area within a State not otherwise included in a geographic area described under clause (i).

(C) FULL-TIME EMPLOYEE.—The term ''full-time employee'' means, with respect to an employer, an employee who normally performs on a monthly basis at least 30 hours of service per week for such employer.

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